Conference of the U.S.P.H.S. with the state and territorial health officers

TRANSACTIONS OF THE THIRTY-NINTH ANNUAL CONFERENCE OF STATE AND TERRITORIAL HEALTH OFFICERS WITH THE UNITED STATES PUBLIC HEALTH SERVICE

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TUESDAY MORNING SESSION

April 29, 1941

The Thirty-Ninth Annual Conference of State and Territorial Health Officers with the Public Health Service, held in the Auditorium, U. S. Public Health Service Building, Washington, D. C., was called to order at nine-forty o'clock a.m. by the Surgeon General, Dr. Thomas Parran.

CHAIRMAN PARRAN: The Thirty-Ninth Annual Conference of State and Territorial Health Officers will please be in order.

We are especially glad this year to have such a substantial representation of our Canadian friends. We are particularly glad to have them participate in the discussions of the next few days. Their presence here, I think, illustrates the closer ties which have developed between this country and the great country to the north of us.

We are especially glad to welcome also the new State health officers who have been appointed since the last meeting.

One should recall that at the Special Conference of State and Territorial Health Officers held in Washington on September 16 and 17, a number of recommendations were made. It is my intention this morning to review briefly those recommendations, to advise you concerning their status, and then to depart from the Surgeon General's usual custom of giving a summary of health conditions and problems in the United States. Instead, it is my purpose to discuss with you briefly medicine and public health in England now, leaving to my colleagues the task of developing the several problems with which this Conference will be concerned.

At the meeting here in September of last year, a recommendation was made to the effect that the Selective Training and Service Act should be interpreted so as to require rather than prohibit the reporting of communicable diseases, including tuberculosis and the venereal diseases. This action has been taken.

The Conference also made recommendations concerning the developing plans of the National Youth Administration to provide more effective health and medical service for its enrollees and voted to cooperate in the several States with the efforts of the NYA.

Then, on the very complicated and important problem of rehabilitation of men disqualified for military service because of correctable physical defects, the Conference recommended that such persons should be entitled to necessary corrective medical care at the expense of the Federal Government.

In respect to the venereal diseases, recommendations were made regarding the routine serological testing of draftees. All of us are gratified that this recommendation has been carried out in present selective service regulations and that all persons are given routine serological tests when they are examined by their local draft boards, before being inducted into service.

Another important matter considered in September was that of public health in the areas of mobilization, and it was urged that the Public Health Service seek necessary funds to reinforce State and local facilities for efficient and expeditious inauguration and operation of emergency health activities. Through the cooperation of the Administrator's office, it has been possible to secure some additional funds for this purpose, and, moreover, a bill is now pending in the Congress to provide substantial appropriations for public health facilities in these critical areas. You will hear more about this bill later.

The Conference also recommended that the Public Health Service seek the necessary funds to provide training for personnel engaged in industrial hygiene. No action has been possible as yet in respect to this recommendation.

The whole problem of drafting and calling to active military duty personnel employed in public health departments was considered, and it was recommended that in plans for national defense the work of the official public health agencies be recognized as an essential part of the national defense program. No definitive action has as yet been taken by the military authorities in respect to this recommendation. We are still hopeful, however, that such action may be taken in the near future.

I should like to bring to my colleagues in the United States, and to my colleagues from Canada, the very warm greetings of many of our mutual friends in Great Britain. Time does not permit the mention of all of them, but I recall particularly those of the Senior Public Health Official Emeritus in Great Britain, Sir Arthur Newsholme, who, while I was there, came to London for the first time since the war had started. I recall, too, those of the present Chief Medical Officer of the British Ministry of Health, recently appointed, Sir Wilson Jamieson, who sent his very warm regards to his colleagues on this side; and of others who are widely known to the profession here, including such men as Professor Ralph Picken, Dr. George Buckin, and Dr. James Fenton, whom many of us met when they were here a few years ago. They, like all of the doctors in Great Britain, are very actively engaged in their current defense efforts.

Modern science has extended the area and scope of medical defense against enemy action no less than it has extended the area and scope of war operations. The whole population of Great Britain is in the battle line. The whole medical profession is in the forefront of the battle. As a member of a Commission on Civil Defense, I spent the month of February in Great Britain. This commission was appointed by the Council of National Defense at the request of the General Staff of the Army. Military science has evolved through the centuries, engaging some of the best minds in every

country in every age. In Great Britain during the past few years there has been developed a new science of civil defense just as intricate, just as complicated in its organization and operation, as military science. Yet there have been few guideposts, no trained personnel. It is commonly agreed that the system, especially in its medical aspects, accomplishes its purpose through an integration of governmental, professional, and voluntary effort.

In planning civil defense measures, the British made two major mistakes: 1. They assumed there would be widespread and intensive raids immediately at the outset of the war with as many as 30,000 casualties a day needing hospital care; 2. They did not envision prolonged continuous night bombing, necessitating the use of shelters as sleeping quarters.

To care for the expected casualties, they doubled the pre-war complement of hospital beds throughout the country by discharging convalescent patients; by evacuating mental hospitals, institutions for the feeble-minded, the aged, etc.; by constructing huts -- temporary wards frequently on the grounds of an existing hospital; by converting large estates into hospitals; and by "upgrading" existing institutions through the addition of operating theatres, the provision of nursing and surgical staffs, etc.

In preparation for war, the country was divided into twelve regions, each with a regional commissioner in charge. Representatives of each Ministry were assigned to the commissioner. This decentralization of government was designed to provide independent self-governing areas in the event of invasion or other enemy action which would disrupt communications. The public health, hospital, and medical services are a part of the regional plan. The war has brought large responsibilities to the Ministry of Health and to local health authorities. Under the Ministry, an Emergency Medical Service was organized. An important first step was a cataloguing

of all hospitals in the country, voluntary and public. The use to which each should be put was decided. The London area was recognized as a special case and its emergency hospital service was based upon ten sectors radiating fan-like from the center outward and extending well beyond the metropolitan area. In each sector the hospitals are classified into Casualty Clearing Hospitals, Advance Base Hospitals, and Base Hospitals, and additional beds are provided for each. The Casualty Clearing Hospitals are near the centers of London and other large cities. A large proportion of regular patients were evacuated, especially from the top floors and glass cubicles. In addition, a specified number of beds in each are kept vacant for casualties.

The Advance Base Hospitals usually are located 15 to 30 miles from the center of the city. The average capacity is 1,000-2,000 beds. Patients are admitted to these hospitals from the Casualty Clearing Hospitals or occasionally directly from first aid posts.

Base Hospitals are located 60 to 100 miles out, and have 1,000-3,000 beds. Patients admitted to these have been classified into specialty groups -- orthopedic, maxillo-facial, neurosurgical, eye, etc.

The Emergency Medical Service pays the voluntary hospitals £3 per week per bed reserved for casualties. When occupied, the rate is £4 per week. Due to the lack of casualties, this has proven a boon to the voluntary hospital budgets. It should be emphasized that there is in Great Britain now essentially one integrated national hospital service for civilian and military casualties. There are no separate Base Hospitals for the Army. Since the whole system has been scrambled together, the British doubt that it ever will be completely unscrambled.

The first-aid posts were organized by the municipal or county health authorities under standards proposed by the ministry. In general the cost of ambulances and of the whole air-raid precaution service is reimbursed by the central government. To train the first-aid teams has been a major task. The need for additional nurses has been met by training more than 120,000 nursing aides and auxiliaries.

While total war creates a demand for many skills, the skill in which there is the greatest shortage is that of the doctor. Last week the President responded to the urgent request of the British Red Cross for American doctors. He said: "To any American doctor who is eligible and able to do service this cause presents a splendid opportunity." Assurance that medical aid is promptly available to all casualties is an important consideration in maintaining morale. Day and night in every operating theatre a surgical team stands by. A doctor is on call or working in every first-aid post. Each night a doctor visits all large shelters. Moreover, a modern army requires many doctors, especially in mobile mechanized warfare. Doctors are needed too in the large factories and to supply the needs of an expanded Navy and Air Corps. So far epidemics have been held in check. Air raid casualties have been fewer than anticipated and have received prompt attention. To accomplish these results, however, the British doctors have been under a severe strain, and medical services for the general population have been reduced. Britain's appeal to the American Red Cross for at least 1,000 of our young doctors is a great opportunity for us to meet a real need. Aside from its humane aspects, American doctors, working side by side with British surgeons and physicians, will acquire valuable experience in the medical techniques of modern warfare. Those who answer this Red Cross appeal will not only have

rare professional opportunities but will also have the satisfaction of giving help where it is sorely needed. I feel certain America's doctors will answer this call. The needs are great, the rewards will be greater.

The British have been very intelligent in using their medical resources to the best advantage. No medical or dental student is allowed to volunteer, and he is not drafted if he passes his examinations from term to term in an accredited school. This deferment is not a "hiding hole" for slackers. Every such student upon graduation or after one or two 6-month periods of internship is automatically called to service for the duration.

When the system of the Emergency Medical Service Hospitals was established, they were staffed by doctors of all ages who were, in effect, requisitioned from civil practice. In London, for example, the staffs of the teaching hospitals located near the center of the city were dispersed to the peripheral hospitals. The regional, sector, and group hospital officers, who themselves had been drawn largely from the staffs of voluntary hospitals, decided who would go to the peripheral base hospitals and who would stay at home. With rare exceptions the assignments were considered as orders. For example, a large proportion of the specialists in Harley Street, with expensive practices and equally expensive offices and other commitments, were recruited for full-time service at a standard pay of £800 per year. They abandoned their practices, moved 50 to 100 miles to a base hospital, and stood by waiting for patients. No casualties appeared during the early months of the war. Naturally some of them drifted back to their accustomed practices. Recognizing the situation, the Emergency Medical Service gave these doctors the choice of continuing on a full-time basis or of rendering a part-time service, subject to call at a lower pay (£300 per year), but with the understanding that if enemy action

increased and the government required their services full-time, such services would be given at the part-time rate. Most of the doctors accepted the offer, leaving skeleton staffs, mostly junior men, at the peripheral hospitals. When the heavy blitz started in September 1940, the full-time service of additional doctors was required in the peripheral hospitals and the financial arrangement was readjusted.

Prior to the war, a medical war organization for the country was perfected. At the head was a Central Medical War Committee composed of the leading physicians, members of the British Medical Association. The Secretary of the Committee is the Secretary of the British Medical Association. To this committee was given the task of registering every doctor and every medical student in the country.

Whenever the military forces requisition a quota of doctors, the Central Medical War Committee allocates the quota to the various communities in Great Britain in proportion to the number of doctors still remaining as related to the population. When the quota is sent to the civil subdivision (country, city, etc.) a local medical war committee, made up of senior doctors, selects the persons who can most easily be spared from present tasks. Doctors in health departments and in important hospital positions are not disturbed. Younger doctors are given preference for service. When a doctor is selected by the local medical war committee he responds in nine cases out of ten. The exceptional doctor may ask for deferment because of some determining personal consideration. His appeal is reviewed. If the decision is not in his favor he has the right to appeal officially to the Central War Committee in London. Ordinarily, financial considerations are given scant attention.

If we are to learn anything from the British experience on the medical front, we must reorganize our approach to the problem of medicine's contribution

to the defense effort. The medical needs of the civilian population should be considered in all recruitment plans, and should be balanced against the military needs. The Health and Medical Committee, under Coordinator McNutt, or a comparable group should be given responsibility for broad national planning. Medical personnel for military, industrial, and civilian health and medical services should be recruited on a quota basis, having in mind the service which each individual physician can render best. Volunteers should not be accepted if they are doing a more essential civilian job. The objective should be to see that each doctor is doing the task for which he is best fitted.

Under a national medical committee, there should be similar committees on medical personnel in each State and in each of the larger communities. These State and local committees, made up of senior doctors, should decide who should join the services and who should remain at home.

All enrolled medical and dental students, all students accepted for admission, and those completing their courses satisfactorily in accredited medical and dental schools should not be drafted until graduation and the completion of an internship, after which those who are physically fit should be required to render a period of service to the government.

The successful local organization of medical defense efforts in Great Britain was possible because for two decades or more Britain has had a nucleus of trained medical officers of health. Without this nucleus effective local medical defenses could not have been organized. We should take steps promptly to double the number of doctors with training and experience in public health and medical administration. In addition, there should be a comparable increase in public health nurses, sanitary engineers, sanitary inspectors, laboratory technicians, and other technical public health personnel. New training centers will be needed for the training of key persons who in turn will train others who will work under supervision in local communities.

Central planning for medical aspects of civil defense should be done. This should include the survey of existing hospital facilities, area by area, and of those structures which can be converted to hospital use. Estimates should be made as to additional hospital beds needed, area by area. The number and location of the beds will depend upon the position of the area in reference to vulnerability to enemy action.

Time does not permit a comprehensive outline of all needed steps. Some of the factors, however, should include provision of additional operating theaters and their protection against enemy action; the protection of existing hospitals; the consideration of safety from air attack in new hospital construction; the number, location, and equipment of first aid posts; the provision of ambulances of a standard type with standard fittings, and the earmarking of commercial vehicles for emergency ambulance service; the planning of decontamination centers; and the training of key personnel in anti-gas warfare in each vulnerable area. I am not recommending all of the above for the whole country but for those areas designated by competent military authorities as vulnerable to enemy action. In addition, special mobile staffs trained in medical defense measures should be available to aid in the organization of such measures in our Territories and possessions and in those areas which we are committed to defend.

It should be emphasized that in the midst of war the British have not curtailed but have extended their social insurance and other social laws.

Finally, let me say that we doctors in the United States should be inspired by the example of our British medical colleagues. In the midst of war they are planning for the peace. The British Medical Association has set up a Medical Planning Commission to "study wartime developments and their effects on the country's medical services, both present and future." In an editorial comment the British Medical Journal points out that the war has

thrown into sharp relief the deficiencies of their peace-time system of administering relief to the sick and of promoting and maintaining the health of the people. "The British Medical Association now proposes to prepare for the return of peace so that medicine may be ready to meet its responsibilities in a world in which many values will be changed, fresh conceptions of society will be formed, and in which new stresses and strains will appear in the moral, material, and economic fabric of the democracy we hold to be our rightful heritage."

I have every confidence that medicine in America will meet whatever demands the future may impose, whether of war or peace. (Applause)

We are very pleased to have with us this morning the Administrator of the Federal Security Agency, who is also the Coordinator of Health, Medical Care, Welfare, Recreation, Nutrition, and Related Activities, as part of the defense set-up. Last year we had the pleasure of hearing from my present boss. The last year's experience in serving under his agency has brought real satisfaction to all of us who have been in contact with him. Never before has the over-all agency under which the Public Health Service operated been more anxious to carry out the purposes and plans which we have been developing. I take great pleasure in presenting to you the Honorable Paul V. McNutt, Administrator of the Federal Security Agency. (The audience rose and applauded)

MR. McNUTT: This Conference has probably never met under graver circumstances. Under any circumstances I should be gratified to speak to this group, and as it is, I am keenly conscious of being admitted to the inner councils of the health officers of the nation during a time of crisis.

Our friends from the Provincial Health Authorities of Canada were never more welcome than they are this year. Not only are we glad to see them for their own sakes, but we turn to them with the interest and understanding

that come from a sense of common aims and of fealty to one another in pursuing them. The manner of life in our North American household has been disrupted by the events across the way. The noise of the destruction is growing louder and more ominous. In the din and the loud voices and the threats launched at us, we have discovered that we have a way of life in which we believe and which we shall not allow to be destroyed.

I think that this Conference, which yearly marks the course of a Federal-State partnership in the cause of health, is one of the most interesting of those that come to Washington. Though it is perhaps not old enough to be called hoary, it is certainly old enough to be described as an honored tradition. This year it is a necessity in the complex business of maintaining and increasing the nation's health and the morale that goes with it. For within the past year health has become important to our defenses and our task has taken on complications.

In happier national circumstances, I should devote the time we have together to recounting improvements in the general level of public health and professional competence. As head of the Federal Security Agency, I have followed your administrative and professional achievements. I have taken a great personal, as well as an official, interest in them, and I share your pride of accomplishment.

The times are too stern for us to linger over what has been done and to be glad. But I should like to say that I have been greatly interested in the story of the Federal-State partnership for national health and in the balance of authority which has been so nicely evolved. The partnership was entered into with the role of the Federal Government defined, by inference at least, as one of last resort. The basic Quarantine Act of 1890 carried the restriction that Federal action should be taken when the President was satisfied as to the danger of the spread of

diseases across State lines. So began the combined efforts of the Federal Government and the States to fight the epidemic diseases. Each supplemented the rather meager resources of the other during what may be termed the lean years of public health. The partnership grew in its capacity for reciprocity--which is another expression for wisdom--and finally matured into a dynamic force for national health with the passage of the Social Security Act in 1935 and the Venereal Disease Control Act in 1938.

Under the perhaps guileless impression that we would be forever free to work for the good life, we nourished this partnership. Now we turn to the work of defending health on the fringes of a great world war.

There is work waiting for the health officers of this continent. As Coordinator of Health, Welfare, and Related Activities in the National Defense Council, I speak from a unique vantage point. There, I am obliged to take the wide view of our activities and our problems. I cannot make specific recommendations as to this, that, and the other thing which must be done in public health. You are the specialists. But I should like to call your attention to the immediate problems which I see from my vantage point.

Defense may be likened to a wedge. At the apex is the soldier. This is one of the stages in history when the man who does the fighting steps up as the most significant of human units. This man must have the paraphernalia of war, and as the living unit necessary to the business he must be fed and clothed and kept in good health. The military authorities are primarily responsible for the details of his existence. They are responsible for safeguarding his health in the limited areas over which they have jurisdiction.

But a good part of the soldier's time is spent in the surrounding civil communities. Even the briefest of times could be significant, since one can pick up an infection very fast. There is where public health comes in. Last summer in the maneuver areas we began our task of resolving the public health problems which impartially plague both military and civil populations. Early in the fall, 9 Public Health Service officers were assigned as liaison officers to the 9 Army Corps Areas to facilitate the relationship between the civil and military authorities.

To solve the public health problems in environmental sanitation, food and milk sanitation, communicable disease control (especially malaria in certain areas), and venereal disease control involves traditional public health services. This part of the work we have pretty well in hand. Money has already been provided for it and more will be forthcoming.

I might say that we started quite logically by sending experts to look into the situation. Since last fall, as you all know, the Public Health Service has had teams of physicians and engineers doing public health reconnaissance, and they have been reporting on areas where military or industrial activities have produced dangerous situations.

Trained personnel from the Public Health Service are being sent into these areas on what has been termed a "lend-lease" basis to assist in the work of our health defense.

Always during emergencies the venereal diseases step forward with the result of complicating a bad situation. It would be ironical, now that we have developed methods of control, if we allowed them to do so in this emergency. Our efforts to control these diseases must be intensified.

As I say, these traditional services--in sanitation and communicable disease control--we have pretty well under control. And we should have. For public health has the structure and is an old hand at the work.

It seems to me, however, that there are two or three problems of grave import which are not under control. In fact, we have scarcely faced the situations realistically.

The military are responsible for the soldier, but public health is responsible for his ally, the industrial worker. In today's war, industrial mobilization and expansion make possible military mobilization and expansion. In the speeding up of industry, our responsibilities in the field of industrial hygiene are multiplying. Able-bodied men are being mobilized into the Army, while women, young adults, and older men replace them in their jobs. These new workers make imperative increased provision for industrial hygiene activities. For all workers, new industrial processes create hazards which demand for their solution the skill of the hygienist, the toxicologist, and the industrial engineer. The significance of industrial hygiene programs in industry's expansion for national defense is far beyond what it was in 1917.

Even in more peaceful days, however, we could not claim that we had more than started this work--and here we are in a crisis that affects industry profoundly.

This is peculiarly your responsibility. Aside from those health services that may be part of accident prevention, public responsibility for protecting the health of industrial employees is vested in health departments.

The Public Health Service is throwing all the resources it can behind this work. It has expanded research in this field and directed it upon the new chemicals and mechanical problems of industrial health.

A consultant nurse in industrial nursing has been added to the staff of the Division of Industrial Hygiene at the National Institute of Health. It is a pity that industrial nursing has not been given its rightful importance in the various State health departments. We anticipate catching up with this lag, however.

It is not only the occupational hazards with which health departments should concern themselves. Public health programs should provide for the worker at work, at home, and in the community. This complete consideration for the worker's health is part of the pursuit of better national health during peaceful years. It is even more necessary as the efforts for defense take on momentum.

Another problem that I would bring forcefully to your attention is the old problem of medical care. What to do for those who need a doctor and have no money? How to provide hospital care for those who lack the financial "Open sesame" to these institutions?

You know what is bound to happen as industrial plants expand and hang out the "Employment" sign. People trek into town from all directions in search of work. When a village of 1,000 is asked to play host to many thousands, the tax structure cannot be expected to stand up to the situation.

To all defense areas will come a large group of people who, if they do not actually arrive in need, will soon fall into need through no fault of their own. Only a very small fraction of this group comes within the accepted connotation of the term "camp followers." They will include skilled or unskilled workmen, people who plan to invest their savings in small businesses, and others looking for jobs behind a counter, or at a cashier's desk, or somewhere in the scheme of a boom in business.

They come and the situation happens to fail them. They do not find the jobs they expected to walk into. The businesses they open fail for some mysterious reason to "click." Or perhaps they do get along and are meeting their needs when illness strikes them or some member of their family. Then they are well into a situation they cannot manage.

We have already seen that the present national emergency is making the distribution of physicians and nurses even more unequal than it has been. Something must be done to counteract the forces doing the unequalizing. The supply of civilian medical and nursing personnel should be maintained and, if possible, increased.

As to the inadequacy of hospital facilities, that is a problem carried over from our peaceful era and due to be aggravated by the circumstances now shaping up, particularly in the defense communities. Some of these needs we hope can be met by the so-called Community Facilities Bill now before Congress.

Closely allied to our state of health in the past and of vital importance now is the problem of nutrition. I should put this as the third important problem in our health defenses. A program to improve national nutrition would have been a necessity in continuing our quest for the good life. And we shall certainly need our nutrition in the activities that lie ahead.

The President has already called the first national conference on nutrition. When the experience and the ideas of the experts have been pooled at that conference, we can judge better in what direction we should start. At any rate, it is something to lay before this group, because this is the group that will carry much of the responsibility.

You may be assured it is the intention of the Federal Government to put all that it can into the program for health. I am hoping that the Congress will make the necessary increases in current appropriations to enhance Federal participation. Pending legislation such as the Community Facilities Bill, the May Act, and the several acts that contemplate aid to communities for hospital construction--all are of interest and merit your support. And above all it is necessary that the States continue their rightful position as leaders in our joint enterprise.

From the vantage point which I happen to occupy, I have tried to emphasize the spots in the public health scene which I think most need emphasis. The problems of industrial hygiene, of medical and hospital care, and of nutrition seem to me the most immediate. It is a relief under distressing circumstances to have something immediate on which to focus. During the week that you met last year, the Low Countries were invaded, and steadily since then a kind of anarchy has set in such as we had never dreamed of. It would take someone with more faith in his secondsight than I have in mine to offer any prediction as to what lies ahead. So I am stopping with our immediate problems, which I think is suitable, for immediate problems are the sort of thing public health should be pursuing up to the very din of Armageddon. (Applause)

CHAIRMAN PARRAN: We find it necessary to shift the program a bit this morning. Mr. Taft was listed next and has not yet arrived but will be here in about ten minutes, and I am therefore going to ask Dr. Crabtree if he will come forward to tell you briefly something of the activities of the Health and Medical Committee of the Council of National Defense. Dr. James A. Crabtree is the Executive Secretary of that committee. (Applause)

Dr. CRABTREE: Physical fitness, mental alertness, adequate nutrition, industrial hygiene, aviation medicine, and public health all stand out in ever-increasing boldness of relief as the picture of the European scene gradually emerges, showing the struggle among men and nations for the right to live or for the chance to conquer.

Yes, these elements are looming larger and larger as the very warp and woof of the pattern of national existence where men and women in an organized society share in common the duties and responsibilities for meeting effectively the forces of aggression. This is because war today is essentially a contest of industrial productivity. Its strategy is not to kill soldiers, but to destroy civil institutions, to break civilian morale, to terrify the helpless and unarmed, and to cripple industrial output. It is this kind of strategy that has introduced the phrase "total war"; and from it emerges the concept of "total defense."

For almost a year, Federal agencies in Washington have been concerned with ways and means of bringing medicine and its related interests to bear most effectively upon the problem of making this nation, through the strength of its citizens, sufficiently strong to meet the challenge of these critical times. Attempts have been directed toward formulating sound plans, making needed investigations, and effecting appropriate coordination of effort in order that a good health job could be done in the support of national defense.

The first step was the creation of a Health and Medical Committee by the Council of National Defense. Made up of a representative of the American Medical Association, who acts as Chairman, the Chairman of the Division of Medical Sciences of the National Research Council, and the Surgeons General of the Army, Navy and the Public Health Service, the

committee was charged with the responsibility for coordinating the health and medical programs affecting the national defense, for studies and investigations as a basis for recommendations and action, and for mobilizing the health and medical resources of the nation.

Later this coordinating responsibility was placed upon the Administrator of the Federal Security Agency, and the Health and Medical Committee was given the function of advising and assisting the Administrator in carrying out his duties as Coordinator of Health, Medical, Welfare and Related Activities.

Six subcommittees were immediately set up, each representing broad segments of professional and community interests within the health field: hospitals, medical education, dentistry, industrial health and medicine, nursing, and Negro health.

The hospital problem is being considered from the point of view of maintaining some reasonable balance between the contributions which must be made to support our military establishments on the one hand, and those necessary to the health interests of the civilian population on the other. The maintenance of an essential nucleus of staff and the deferment of internes from military duty prior to completion of a minimum standard period of internship have been considered thoroughly along with the other elements of the broad problem of professional personnel, a problem which not only impinges upon hospital and medical service but which runs squarely into some of the basic elements of medical education.

Although certain statutory considerations limit present formal national policy, one can say that without exception the Federal agencies in Washington having administrative responsibilities in this connection

are in complete agreement on the need for an uninterrupted supply of medically trained graduates to meet the increasing needs of the country, both military and civil.

The question of maintaining essential hospital supplies and equipment has been considered. Negotiations are now under way to obtain a priority status for civil hospitals which will enable them to purchase essential supplies, more particularly surgical equipment.

Consideration has been given to the need for extension of hospital facilities in critical defense areas where the great influx of population seriously overburdens existing hospitals, if any in fact do exist. Legislation is pending in the Congress, which, if enacted, will provide for direct Federal assistance to the defense communities most greatly in need with regard not only to the provision of hospital facilities, but also other acutely needed community services such as water and sewage disposal systems, health centers, and schools.

The committee has been active in industrial health and medicine. Specific recommendations have been made and action taken on many of the pressing problems related to our enormously expanding industrial activity. These recommendations have to do with the training of large numbers of professional and technical personnel in industrial medicine, hygiene, and nursing; with expansion of the industrial hygiene work of the U. S. Public Health Service; with safeguarding the health of workers employed in the industrial establishments of the Army and Navy; and with further researches into many of the newer industrial processes in order to determine the hygienic factors involved.

The Public Health Service today has five teams consisting of a specially trained physician, an engineer, and a chemist, with additional personnel as required, who are available to go anywhere in the country

on short notice to provide technical consultation in cooperation with State and local health agencies, or to any defense industry which may require assistance either in defining its industrial health problems or in training its own technical personnel. With additional funds recently appropriated by the Congress, this force will be tripled relatively soon.

The contribution of nursing to industrial health, consideration of which, in my judgment, is long overdue, now finds a prominent place in the discussions of those primarily concerned with meeting the several health problems of industry.

Under the joint sponsorship of the Public Health Service and the Subcommittee on Nursing, a nation-wide inventory of registered nurses is well under way, the results of which should serve a purpose similar to that of the inventories being carried out by the American Medical and the American Dental Associations.

Most authoritative opinion seems agreed on, and recent Army experience in no way contradicts, the point of view that the present supply of qualified nurses is too small to meet the demands imposed by the emergency. Certainly there can be no doubt of a shortage in the event of mobilization. A proposal is under consideration for providing refresher courses for a large but unknown number of nursing graduates who for various reasons have relatively recently given up or interrupted their nursing careers. Also, it is expected that the nursing schools of the country will be encouraged to increase their enrollments to the fullest extent consistent with the maintenance of acceptable standards of education.

Health and medical considerations have entered intimately into the planning and central administration of the selective service process -- an unprecedented peace-time national enterprise. The importance to

both the public and the individual of sound medical procedures in connection with selective service needs no comment. But the results of these procedures, although still tentative, are bringing into prominence a situation which challenges the best efforts and fullest ingenuity of American medicine and public health. It is not merely an opinion but a matter of record that from 30 to 40 per cent of men, American citizens otherwise available, are now found unacceptable for military duty because of physical defects, many of which are remediable. We all, I think, take pardonable pride in the quality of American medical practice. I pose the question, however, whether the mere pointing with pride to our standards of education, to our quality of medical service, to our ratio of physicians to population, to our centers for medical research, and to the remarkable attainments of our many medical geniuses can satisfy the impelling argument raised by this cold, hard fact -- that from one-third to one-half of our men are considered physically unfit to discharge their highest duty to their country. Can Public Health afford to continue in its present attitude of complacency in regard to the provision and distribution of medical service facilities for the man on the street? For example, are we, in the light of these figures, prepared to tolerate and even defend a continuation of present day schemes of school health services, geared as they are to elaborate, costly, time consuming, even aggressive programs of "case finding" but hampered by the philosophy of take-what-you-have-and-make-the-most-of-it in relation to facilities and opportunities for corrective and rehabilitation services? A special commission has been created by the Health and Medical Committee to study this situation as it relates to the over-all problem of manpower which is certain to become of increasing concern in the event of a prolonged national emergency.

We cannot lose sight of the fact that total defense involves the recruitment not only of men and materials, but also of knowledge and ideas. Newer methods of warfare require newer methods of defense. These must apply to military medicine and hygiene no less than to anti-aircraft measures or improvements in tank construction. The best talent of the country is being recruited to extend and advance our knowledge of the human problems intimately related to the preparedness effort.

The fields of aviation medicine and physiology, neuropsychiatry, chemotherapy, tropical diseases, nutrition, industrial toxicology, and the several specialties of medicine and surgery are being explored aggressively because of their strategic importance to effective military effort. The streamlining of military organization and tactics has literally over-night outmoded a great majority of traditional principles of medico-military administration. One of the basic problems of medical research is to resolve the many technical difficulties which limit the mobility of military units of medical service.

In the field of nutrition we face today a very different situation than in 1917. Then a Food Administration was set up which had as its principal function the restriction of the use of such commodities as wheat, sugar, and fats. Today we have substantial stocks of all essential foods. In addition, knowledge of food values has been almost completely transformed. Our first task is the improvement of the nutrition of the American citizen; secondly, we have the job of supplying Britain and her allies with the kind and quantity of food they need, yet at the same time protecting the interests of American agriculture and the American consumer.

Large concentrations of troops in camps and cantonments and vast expansion of many defense industries have, in many communities, brought about an influx of new population of such magnitude as to create problems of health, housing, sanitation, medical and hospital service, which perhaps only you can adequately describe.

Although the Public Health Service has assigned a Senior Medical Officer to each of the Corps Area Headquarters of the War Department to facilitate coordination of civilian-military relationships; although additional Public Health Service personnel will be available for assignment to the more critical areas as rapidly as they can be recruited and trained; and although "flying squadrons" of expert personnel from Federal sources are devoting their fullest energies to the assistance of the more strategic industries, nevertheless the problems are essentially local or at most regional. Nor are they, by and large, in any way unique in character. Therefore, the question as to whether American Public Health within its present framework of organization is equal to the task of supporting and enhancing military and industrial mobilization becomes a matter which is squarely up to each one of you.

And let there be no doubt in the minds of any of us as to the gravity and the extent of the emergency which exists now. "It's later than you think" is no idle play on words -- on the contrary, it is an expression of stark realism. The maintenance and preservation of social gains is an altogether commendable objective, but in times such as these, social concepts are, in my judgment, distorted when they fail to take into account the preeminent and preferred status of the local problems directly incident to military and industrial mobilization.

Several Federal agencies are diverting an increasing proportion of their resources to the more pressing emergency situations, and I would like to suggest to this Conference the necessity for similar action by the several State health agencies.

I have attempted here to cite only a few typical examples of the many detailed situations with which the Federal Government is concerned in the great human responsibility of raising the health level to meet the needs of an all-out national defense. No over-all plan or blueprint has been drawn up in Washington, setting forth specifically the tasks of each individual or of each community. No plan worth the paper on which it is drawn could be developed in Washington which ignored the fundamental principle that sound health preparedness depends primarily upon sound and skillful local community organization. This is your job. The exigencies of the times do not alter the character of your responsibility: They do impel its urgency. (Applause)

CHAIRMAN PARRAN: Dr. Coffey, I think we will shift to the subject which you are going to present, "Pending Federal Health Legislation."

DR. E. R. COFFEY: Dr. Parran, Members of the Conference: I am imposing myself on you this morning, not to tell you anything new, but just to bring you up to date, perhaps, on the pending health legislation in Congress. So often we have had mentioned to us a bill by such and such a person, without reference to it by number or content, and it seemed worth while to take about ten minutes of the Conference's time just to mention to you, perhaps by number and author or sponsor, the various health bills now under consideration by Congress, and their purposes.

As a matter of passing interest I may say that during the 76th Congress 16,104 bills and joint resolutions on all subjects were introduced and, of this total, 107 can be classified as pertaining to public

health. In the present Congress, the 77th, from January 3 through April 21, 1941, a total of 6,061 bills and joint resolutions on all subjects have been introduced. Of this number 56 pertain to matters of public health interest. During the 76th Congress 13 legislative health measures became law and up to the present time the 77th Congress has enacted one bill, H. R. 3204, which was an appropriation act providing, among other things, for $525,000 to enable the Public Health Service to assist the State and local health authorities in health and sanitation activities related to the National Defense Program.

Many of the pending bills, while related to public health, are of minor or local interest. For instance, several provide for marine hospitals to be operated by the Public Health Service; one provides for a survey of physical education resources; others provide for amendments to the Social Security Act regarding disability benefits; another provides for a survey of narcotic drug conditions in the United States. This measure, H.J.Res. 99, was presented by Mr. Coffee, Congressman from the State of Washington. It is of interest to note that this resolution states that in a recent survey in the State of Washington it was disclosed that there were 3,500 addicted persons, as compared with 350 reported by the Federal Narcotic Bureau. The Public Health Service is mentioned as the agency to conduct the proposed survey in cooperation with the States, Territories, municipalities, and public and private agencies interested in the narcotics problem.

One bill provides for regulating the importation of dairy products into the United States.

Several of the more important bills with which it seems advisable that the State health officers become familiar are:

H.R. 3570, introduced by Mr. Lanham of Texas, which provides for an appropriation of $150,000,000 to be used, in accordance with directions

and regulations as prescribed or approved by the President, to assist local communities in providing essential facilities where the need has arisen incident to the National Defense Program.

It is my understanding that, only within the past few days, a companion bill or a similar bill has been presented. It is S. 1375, introduced on April 25 by Mr. McCarran, of Nevada, and the title of that bill is "To provide for certain community facilities made necessary by the exigencies of national defense." I haven't had the opportunity of seeing the bill, so I am unable to tell you just how it varies from the bill which was introduced by Mr. Lanham.

H.R. 1791, introduced by Mr. Pfeifer of New York, provides for the establishment of a Department of Health. To head this Department it is proposed that there shall be a Secretary of Health appointed by the President. The bill provides for the transfer to this one Department of practically all public health activities now being carried on by the Federal Government.

H.R. 1110, introduced by Mr. Spence of Kentucky, is one of four bills, the other three being H.R. 3778, H.R. 4106, and S. 1121, which provide for the creation of a Division of Water Pollution Control in the United States Public Health Service.

H.R. 1007, introduced by Mrs. Rogers of Massachusetts, provides for an amendment to the present act establishing the National Cancer Institute. This amendment authorizes an initial appropriation of $2,300,000 and such sums thereafter as may be necessary to be used by the Public Health Service in assisting States, counties, cities, and other political subdivisions of the States to extend and improve measures for the diagnosis, treatment, and control of cancer.

H.R. 995 and H.R. 161, introduced by Mr. Patrick of Alabama and Mr. Voorhis of California, respectively, provide for amendments to the Social Security Act with reference to medical and surgical care for the blind and medical care for transients.

H.R. 70, introduced by Mr. Elliott of California, provides for the control of tuberculosis among migrants. The appropriation called for is $1,000,000 for the fiscal year ending June 30, 1941, and is to be allotted to the various States by the Public Health Service upon the basis of the migratory population, the extent of the tuberculosis problem, the existing facilities for the care of tuberculous patients, and the financial needs of the respective States.

In other words, this is another grant-in-aid plan directed particularly toward the medical care of transients, which we all recognize is one of the trying problems in many of the States.

H.R. 3463, introduced by Mr. Voorhis of California, H.R. 3492 by Mr. Kilday of Texas, H.R. 3968 by Mr. Houston of Kansas, and S. 195 by Mr. Murray of Montana all impose additional duties upon the Public Health Service in connection with the investigation, treatment, and control of tuberculosis.

So you see we have four bills, all related to the treatment and control of tuberculosis and all somewhat comparable, but varying somewhat, of course. I think these bills serve to emphasize the importance which Congressional leaders are placing upon tuberculosis as one of our public health problems.

H.R. 2475, introduced by Mr. May of Kentucky, prohibits prostitution within such reasonable distance of military and/or naval establishments as the Secretaries of War and/or Navy shall determine to be needful to the

efficiency, health, and welfare of the Army and/or Navy. This bill passed the House on April 21, 1941 and has been referred to the Senate.

Somewhat comparable are bills, H.R. 4000, introduced by Mr. Houston of Kansas, and S. 860, introduced by Mr. Sheppard of Texas, which provide for the control of the sale of alcoholic liquors to the members of the land and naval forces, and for the suppression of vice in the vicinity of military camps.

I think you can all recognize how important this first bill of Mr. May's is, and the fact that it has already passed one body of our Congress makes it appear very likely that it is going to be given support.

S. 509, introduced by Mr. Murray of Montana, provides for the general welfare by enabling the several States to make more adequate provision for the control and prevention of industrial conditions hazardous to the health of employees. It provides an initial appropriation of $1,000,000 to be administered by the Secretary of Labor. Assistance is to be given to industrial hygiene programs in the States under the supervision of the State Labor Departments.

S. 193, introduced by Mr. Murray of Montana, provides for compensation for disability or death of workers from silicosis or other dust diseases. These activities also are to be under the administration of the Secretary of Labor.

H.R. 584, introduced by Mr. Fulmer of South Carolina, provides for the promotion of national health and welfare through appropriation of sums for the construction of hospitals. This bill authorizes assistance to States, counties, health or hospital districts in providing better health and medical services through the provision of needed hospital facilities to serve rural communities and economically depressed areas. The administration of this bill would be under the Public Health Service.

S. 1230, introduced by Mr. Brown of Michigan, is a somewhat comparable bill providing for the Public Health Service to administer a program of assisting States and their political subdivisions to provide and maintain adequate hospital facilities.

S. 783, introduced by Mr. Murray of Montana, provides for amending the Selective Training and Service Act so that practicing graduates of medical schools and schools of dentistry shall, in lieu of induction into the land or naval forces of the United States for training and service, be commissioned as officers in the Medical Department Reserve, Officers' Reserve Corps, and ordered into the active military service of the United States; and further, that medical students, dental students, hospital interns, resident physicians and dentists, and teachers at medical and dental schools shall be exempt from training and service and, if they are members of a reserve component of the land or naval forces, shall not be ordered to active duty except in time of war.

This bill, I might say, provides for considerable amendment to the Selective Service Act. Not having the Selective Service Act before me, I might be a little confused on what the Murray bill provides, but I assure you that, as State health officers, it merits your attention because it seems to begin to meet some of the problems with which we are critically concerned.

S. 489, introduced by Mr. Capper of Kansas, provides for adding to the Social Security Act a Title 12 relative to grants to States for health insurance. This program would be under the administration of the Social Security Board.

This is another indication, of course, that Congress has not given up the thought of making some provision for generalized medical care, at least to the needy.

S. 194, introduced by Mr. Murray of Montana, authorizes the Public Health Service to carry on research regarding the cause, diagnosis, and treatment of dental diseases. An initial appropriation of $75,000 is provided.

So far as this bill is concerned, I think that we can recognize the importance of providing for a study into an activity in which we are all vitally interested and on which very little work is being done at the present time.

H.R. 1074, introduced by Mr. Schwert of New York, provides for an appropriation to assist the several States and Territories in making adequate provision for physical education in schools, including athletics; instruction and guidance in healthful living; wider recreational use of school facilities; and the development of school camps. The initial appropriation authorized is $50,000,000. The administration of this bill would be under the United States Commissioner of Education.

Thank you for bearing with me in such an uninteresting presentation, but it fell to my lot to do it, and here I am. Thank you very much. (Applause)

CHAIRMAN PARRAN: Thank you, Dr. Coffey.

The importance of coordination in the several fields of public health, welfare, nutrition, medical care, recreation, and other activities has received increasing attention. I am very happy to present to you our next speaker who is extremely well qualified to tell you of what is being done in these directions. I have the pleasure of presenting Mr. Charles P. Taft, Assistant Coordinator. (Applause)

MR. TAFT: Dr. Parran, Ladies and Gentlemen: I appreciate very much the chance of coming over. I want to apologize for being behind schedule. We had a telegram on Saturday from the Community Chest executive in Scranton,

Pennsylvania, to the effect that the Wyoming Conference of the Methodist Church had adopted a vote condemning the United Service Organizations campaign, which we are relying on to raise a good deal of money to operate our recreational buildings, on the ground that the Government was passing the buck to the religious organizations, and that the Government was providing devices -- here I am not sure what they were talking about -- within the camps to interfere with the morals and safety of the young men who were there. So I had to go this morning to talk to the Commission of the Methodist Church on the question of their relationship to our whole program, and they kept me there a little longer than I expected. That is why I am late.

It has been a great privilege to come to Washington, to learn something about the method of operation of government departments, and to find what seems to me the ideal government department, the United States Public Health Service. (Applause) We are counting on you for the principal, in fact the entire, field operation of the health program of the United States. It is you who must do this job which looms so large in all communities where there are camps or defense industries.

The Coordinator was designated in December to try to handle this job in these communities. In the last war, except for recreation, there was no central authority or executive who was trying to pull together such a program, and as a result we had pretty much of a mess in a good many places around the country where there were camps, especially where the local community was utterly unable, so far as its financial resources were concerned, to undertake the job and to get it done.

We operate in six major fields. The first, obviously, is health, and in that we work through the Public Health Service and through your organizations within the States and localities. Advising us in this work

we have the Health and Medical Committee which is made up of the three Surgeons General and of certain other representatives of the National Research Council and of medicine in general. The Health and Medical Committee is setting up, among other things, a research program supplementary to that conducted by the United States Public Health Service. The Public Health Service research program involves, I think, approximately $2,000,000 a year, and the amount we are asking of Congress for supplementary research is about $1,500,000, to be devoted especially to the study of problems which have been presented to the Health and Medical Committee by the Army and Navy.

The nutrition program, which originated with the Consumer Division of the National Defense Council, was switched over into our general field, and we are now working with three or four of the divisions of the Department of Agriculture, with State nutrition committees in each State, and with such local organizations as have been built up gradually either through the divisions of the Department of Agriculture or through the State nutrition committees. M. L. Wilson, head of the Extension Service of the Department of Agriculture, is the chairman of our Committee on Nutrition.

In the field of family security, the problem pretty closely parallels the transient problem. In most of the communities to which I have referred the specific defense aspects of this problem are those which have to do with families stranded as a result of the heavy importation of labor to do the construction work for naval stations or defense industries. Here again we have the benefit of the advice and consultation of the Committee on Family Security which is headed by Jane Hoey, the head of the Public Assistance Division of the Social Security Board.

In education we have a very serious problem. In the fall, or at the end of the year, Dr. Studebaker secured a report from most of the State Departments of Education which indicated a displacement by next fall of 250,000 children for whom there would be no school facilities. That may be slightly exaggerated, but it is certainly fair to say that there are over 150,000 children who will be displaced and for whom the Government has a very decided responsibility.

Take the Norfolk area. The estimate there is that something like 3,500 children are living on government property. That means they are either the children of enlisted personnel living on the post, or they are living in government housing projects which are not on the tax duplicate and from which, therefore, no tax money is forthcoming to pay for the cost of education.

In that area, incidentally, it is estimated that by next fall the number of children who will not be living on government property and who will not have any school facilities will be about 3,800; so we have a serious problem of providing such facilities. Generally this problem arises in communities in which the tax duplicate will not produce taxes, in which the increased values brought about by new activity and new population will not produce values for a year and a half or two years, or in which there will be no increased value and there are no financial resources to handle the problem. In such cases, we have worked through the Office of Education, as I say. There is no advisory committee to help in this field.

In recreation there was no general government program. WPA has been a supplementary organization. It has done an outstanding piece of work, but generally speaking its executive personnel in that field, and many of its other workers, have been drawn off gradually by increased employment and opportunities in other related fields. Therefore we have set up in

our office a staff on recreation headed by Mr. McCloskey who has been the the head of recreation of the City of New York under the Board of Education. We have a field staff of about forty now, which will be increased to about sixty. Of these, eight or ten are regional and the balance are situated in specific localities, places where there is an especially difficult problem. The job of these men is not to run a program, but to stimulate its operation either by the local community or by a local recreation council, or, if there are not sufficient resources in the community, to inaugurate activities by bringing in the United Service Organizations to furnish a staff. The Administration has asked Congress for an appropriation of $150,000,000, to which I will refer in a moment, which will provide, among other things, recreation buildings, and we expect the United Service Organizations to operate these buildings in places where we cannot secure municipal or other contributions to operate them.

The United Service Organizations consists of the Y.M.C.A., the Y.W.C.A., the National Catholic Community Service, the Jewish Welfare Board, the Salvation Army, and the Traveler's Aid Society. In order to conduct its operations the United Service Organizations will carry on a campaign from the 3rd of June to the 3rd of July by means of which it hopes to raise $10,765,000.

The sixth field in which we are operating is that of legal and protective service which has to do primarily with the venereal disease problem. The job was handled in the last war by the Training Camp Activities Commission of the War Department, at the head of which was Raymond Fosdick, assisted by Bascom Johnson who has since then been with the American Social Hygiene Association. Mr. Johnson is now on my staff and is in charge of this operation.

This work has two phases. The first is an educational program which seeks to secure from the local officials a full enforcement of the local and State laws on prostitution and which attempts to build up public opinion in

support of this effort. This is done by presenting the public with the facts as to the incidence of venereal disease under the segregated or toleration policy, and under the policy of suppression. The policy of suppression was officially adopted by the three Surgeons General a year and a half ago, was approved by them last year, and has begun to get into active operation. We don't delude ourselves about it. We realize that there is a considerable body of public sentiment which favors toleration or segregated areas. We realize, also, that there are many officers in the Army, sometimes commanding officers, who are sympathetic with this viewpoint. But we are determined to do an educational job that is going to produce the desired result, that is, reducing the venereal disease rate by reducing the opportunity for contact.

The other phase of this program, the protective service, involves the building up of a staff of women who will undertake to stimulate in the local communities proper measures for handling especially the juveniles, or what one of our regional men described as the amateurs and "semi-pros." This is to be done, in the first place, through the establishment of venereal disease quarantine hospitals for which we expect to use some of the community facilities money, and, secondly, through the setting up of detention houses, separate from the ordinary local jails, in which girls can be kept until arrangements can be made to get them back to their own communities, to get them a job, or, by a general social case worker approach, to secure their rehabilitation in the community.

In this phase of our operations we are working very closely with the Children's Bureau which has asked for a supplementary appropriation, a deficiency appropriation for this year, and an appropriation to carry on during the next year so that the local staffs can be increased in order to take care of this kind of operation.

Now let me specify a little more about the recreation job. It is a leisure-time activity problem and we are, therefore, giving every support

to the Army's program for recreation inside the camps, which is getting under way and which we expect will do a first-class job. In the community, the men we send in start by trying to get a community council, including all interests that are involved, who will first of all build up needed facilities: that is, comfort stations and places to sleep. When the boys go to town on Saturday, unless the town is right next door to the camp, they are going to stay in town regardless of how comfortable their beds may be back in camp. I have some pictures in my office of the Navy Y.M.C.A. in Norfolk on Saturday night, showing the gymnasium full of cots, a large hall full of cots, boys sleeping on the stairs, sleeping on the writing tables, and even sleeping in the telephone booths.

When I testified before the House Committee on the Community Facilities Bill, one of the members said to me, "Well, what do they go to town for? Why don't they keep them in camp?"

I said, "Were you in the Army?" and he replied, "Yes."

I said, "All I can say is that when they get a pass and go to town on Saturday, they are going to stay there." They are not going to go back unless the camp is, as I say, practically next door.

The next phase of this program involves the whole community attitude, the development of normal social contacts within the community for the boys in the camps. That is a real job of public relations. Our man can't do it, but he can build up committees within the community which will gradually bring this about, which will bring the soldiers in contact with the churches, with the fraternal organizations, and with every kind of normal community activity.

The next job of our representative is to get together the commercial recreation people and to try to form an organization among them which will keep their own standards up, and which perhaps will make arrangments for the admission of men in uniform at lower rates to baseball games, movies, or

whatever kind of commercial entertainment there may be. Through such an organization the influence of the honky-tonks and undesirable elements in commercial recreation can be minimized.

And then we hope to have the United Service Organizations, as I said, working in these organizations and running the recreation buildings. Our man will be the coordinator for the U.S.O. group, and it will take some coordination--we don't delude ourselves about that, either. On the national level the organizations in the U.S.O. are determined to work toegether, but when you get together a Y.M.C.A. secretary, a Catholic Community Service man, and a Salvation Army officer who never saw each other before, and they come into a community and have a job to do, it will take a whole lot of riding herd on them to be sure they really cooperate; and we are determined to have them them cooperate.

These buildings are going to carry the name "United Service Organizations" on them, and nothing else. We do expect to have them designate one agency which will be responsible and which will have the last word in the building, although in some cases it will be a joint operation; in others an individual organization will be operating the building, and there will be some indication inside as to which organization it is.

The Community Facilities Bill is expected to provide $150,000,000 for hospitals, clinics, malaria control, quarantine hospitals, schools, transportation to and from schools, recreation buildings, and many miscellaneous items. The estimate of the Public Health Service on the needs of all the communities is $150,000,000 by itself, but that is a long-time program, or at least a program for several years. The combined estimate covering the Public Health Service, the schools, and the recreation buildings for the first year does come within $150,000,000.

I might say that this bill, H. R. 3570, has bogged down somewhat in the House. A new bill, which is an improved bill, has been introduced by Senator McCarran in the Senate, S. 1375. We are hoping that the introduction of bill 1375 in the Senate will get the thing through a whole lot sooner and get us under way rapidly in trying to meet the problems in which you are specifically interested.

Our local man in these thirty -- eventually it will be as high as fifty localities -- is primarily a recreation man, but that is partly due to simplification of organization. He is a man to whom you can report any specific health or sanitation problems on which you want action; he will take them up at once with our regional organization. We have designated the regional directors of the Social Security Board as our regional coordinators, and they have called together, as some of you may know, a regional advisory council of all Federal agencies involved.

At the first of those regional meetings, they did not invite the State or local health officers to be present. At the later ones, they have asked the State health officer to serve on the council, and that, I am sure, will be our official policy. So I hope that all of you will join in the activities of the council.

Within the next week or ten days we expect to start a series of combined planning trips. These will not be just another one of the many surveys by various Federal agencies. These planning trips will bring together those who are really concerned in the planning and spending of the money involved in the Community Facilities Bill. We have made one trial trip to Camp Leonard Wood in Missouri. We are hoping to start the process, as I say, within ten days, with visits to regional people, in the order of the seriousness of their problems. We are looking forward to having your cooperation when we do

that; we want you to be in on it. If by any chance you do not get an invitation, I want to assure you that it is an oversight. We intend to visit the State health officer and the local health officer in each case, in order to formulate the exact plans that we want to carry out with the money involved in the Community Facilities Bill.

You can also help very greatly by giving us information while you are here. This may have been suggested to you already, but I want to repeat it. If you can give us information as to situations in which the calling of reserve officers is seriously draining your supply of doctors or public health personnel in any one of your communities, we want it specifically, because we are making plans to bring very vigorously to the attention of the Army the recommendation for a Medical Procurement Board made by Dr. Parran in his report on his trip to England. If before you go you will leave here at the Service any specific information that you can give us about situations of that sort, it will be a very great help to us in securing some kind of favorable action on Dr. Parran's recommendation.

Thank you very much, sir! (Applause)

CHAIRMAN PARRAN: Thank you very much, Mr. Taft.

Knowing that Mr. Taft wants to leave soon, I would ask any of the State health officers if they have any reports or comments to make concerning some of the situations hich he has described. I refer particularly to the last suggestion he made with regard to the draining of local communities of essential health activities as the result of the Army recruitment policy or the calling to active duty of reserve officers in the Army or Navy.

DR. CLIFTON F. McCLINTIC (West Virginia): I don't know whether this is in line, Dr. Parran, but we have a small area at Morgantown, West Virginia, where we have an influx of eight to ten thousand people, and they are living

in trailers and renting their cars overnight to sleep in, and we are not able to get a health officer there. We need two men in venereal disease control and we need several sanitary engineers.

MR. TAFT: Is that a construction job?

DR. McCLINTIC: No, the Government is financing the erection of the du Pont plant there.

Mr. TAFT: Let me say just a word about the situation in connection with construction jobs. Those jobs, of course, are scheduled for completion before a definite date. We have had a difficult enough time to get our program started for a long-time operation in these communities, and although it isn't very admirable we have come to the conclusion that there just isn't anything we can do about construction situations. I realize they are a headache to you, and yet we know that we couldn't get under way quickly enough and that we couldn't get money quickly enough to do anything in reference to construction jobs. Where, however, such jobs are going to last for more than a few months, we would like to have it called to our attention, because then we do want to do at least something as rapidly as we can.

DR. S. H. OSBORN (Connecticut): I welcome the matter brought forth by Mr. Taft, because I happen to be a member of a committee that struggled all day Sunday, and struggled during the past year, with regard to what to do with the problem of supplying public health personnel in the majority of States where they are being drained out today. We know that the Surgeons General of all three departments are in favor of maintaining civilian health, but it can't be done the way the thing is going today. So we certainly are delighted to have you ask us for contributions along that line because unless something is done we will have to train and train and train more, and the personnel will be inferior to what we now have.

On the other hand, all the State officers realize the war can only be won -- if we go in -- by having a strong Army, so there we may have to dilute some.

The other thing I would like to suggest is this: Many of us heard last year and this year about the fact that State health officers are going to be contacted by the Federal services in regard to different things that are going on. We are surely going to be called upon to sit in, and so forth, but the trouble is, we are not shorthand artists and we can't put down all these memos on the National Youth Administration, for example, and these groups mentioned by Mr. Taft. Where are they to be contacted? If we could have a list of matters about which we are supposed to be contacted and asked to serve, so as to have a green light at the top of the page saying, "These things you must serve on, because they want you and need you, and are endorsed by Surgeon General Parran," it would be a great help to us.

MR. TAFT: I can answer that specifically. The first meeting of the Advisory Council on the Federal level was held in January. They agreed to set up regional advisory councils which include all of the Federal agencies operating in this field; so you should not now, ordinarily, get requests from individual agencies except as they have been cleared by the Federal Advisory Council within the region. The NYA specifically should be operating through a regional council which would include, from here on, at least, representatives of the heads of the State health departments of the States within the particular region. We are making every possible effort to reduce the number of calls upon local communities or States by Federal agencies, and are channeling them through the one set-up which is now provided in the twelve regions of the Social Security Board.

I don't know whether you are familiar with these regions. The first is New England at Boston; the second the State of New York at New York; the third

is Pennsylvania and New Jersey at Philadelphia; the fourth is the one that goes down to North Carolina and takes in Virginia and Maryland and Delaware, and that is at Washington; the next one is in the Southeast and has its headquarters at Birmingham; the next takes in Louisiana and Texas, and has its headquarters at San Antonio; four States in the Midwest, Arkansas, Missouri, Oklahoma, and Kansas, have their headquarters at Kansas City; the region including Michigan, Ohio, and Kentucky has its headquarters at Cleveland; Chicago is the center for Indiana, Illinois, and Wisconsin; Minneapolis is headquarters for the one in the Northwest; Denver is the one for a section that goes straight across the country from north to south; and San Francisco is headquarters for the Pacific Coast region. I think I covered all of them.

CHAIRMAN PARRAN: Are there any further questions?

DR. THOMAS F. ABERCROMBIE (Georgia): I would like to know if Mr. Taft or anyone could assure State health officers that our key medical men will not be drawn in, with the result that our program will be disrupted. Is there any prospect of being assured of that?

MR. TAFT: We can't assure you of that at all, but we are starting to shoot from every angle to get the War Department to set up a Medical Procurement Board. Our general idea is that we probably have a shortage, but that at least the shortage ought to be distributed. It ought not to be concentrated in a few places, and the only way we can see to avoid this is through the recommendation made by Dr. Parran for a Procurement Board which would use all available information and would break down the restrictions that now exist on commissioning doctors who are available but who don't happen to be in the Reserve Corps. We can't promise you anything. All I can say is that we are going to work on it.

DR. ARTHUR T. McCORMACK (Kentucky): I would like to bring this to Mr. Taft's attention. I want to thank you very much for this discussion because it has been very helpful in every way, showing the seriousness with which the

planning is being done. We have already lost nine of our key health officers in local situations in Kentucky. We happen to have more health officers because, unfortunately, we have more counties than any of the other States. Now we have added a number of other counties on account of the emergency situation, and we are having great difficulty in getting qualified personnel for those counties, in addition to the problem that was handed to us by taking away nine of our key men. Those nine men who were qualified in public health, most of them having finished the training course provided through the Social Security Act at Harvard or Johns Hopkins, are all giving medical care. None of them is being used for the purpose for which he was trained. Their special talent is being wasted.

You see, in Kentucky, we learned to fight a long time before we started thinking, and whenever a fight starts, we all want to get in it, and that includes our country boys, doctors as well as other individuals. We have more volunteers in the Army in proportion to our population than any other State, naturally, because we are that kind of a State, as Mr. Taft well knows. During the last war our rural counties were robbed of their doctors when they went into the Army. We have just begun in the last five years to get young men back into those rural districts and to get the people there adequately treated. Now, of all those young men who are in there, and have been there for but a short time, the majority were in the Reserve Corps. They have all been called into duty, and we have many counties in Kentucky now in which there is not a single man under 65 years old, and a number of others in which there isn't anybody under 55 years old. Many of them are disabled, unable to do anything but take care of office calls.

If we are going to preserve this thing we are fighting for, the most important thing is to preserve the rural population and not arrange matters so that they have to come to town in order to find facilities to take care of their

women in childbirth, or their children during illness, or their families during the rest of the time. It is extremely important, it seems to me, that we center on such a procurement program as will avoid decimating the medical population and the service population of our agricultural sections.

CHAIRMAN PARRAN: Are there any further questions or comments or reports on individual situations from other States?

DR. HARRY F. PARKER (Missouri): Dr. Parran, I might say we were very happy to have Mr. Taft out in Missouri, and especially around the Camp Leonard Wood area. I might say that I will have lost 60 per cent of the medical officers in the State health department to the Reserve Corps.

MR. TAFT: Have they been called?

DR. PARKER: Several of them have been called and have gone; others are just waiting to receive their call. Certainly I am not going to ask for deferment because I don't want to have the responsibility of being charged with delaying their promotion.

I have five county units in the making around the area, and if, after the men are in the Army, I could have them assigned to me from the Army as county health officers, it would help to solve the problem a great deal.

MR. TAFT: Dr. Parran tells me the Army has refused to do that.

CHAIRMAN PARRAN: Is that correct, Colonel Simmons?

COLONEL J. S. SIMMONS (U. S. Army): I am afraid I can't speak for the office, but it doesn't sound right.

DR. ARBONA (Puerto Rico): Mr. Chairman, in Puerto Rico we have quite a difficult situation. In normal times there are not enough physicians in the Island and the health department has quite a difficult time getting physicians to work in public health. About ten of our physicians have been drafted by the Army, or called. Quite a number have been deferred and I do not know exactly

when they will be called. This creates quite a difficult situation for the department of health in the Island.

MR. TAFT: I want to say that we are very concerned with this situation. It is certainly a very difficult one, and it applies not only in the matter of health to which the doctor refers. Their water supply is inadequate. The Virgin Islands next door, incidentally, have been buying water by the ton from Puerto Rico, and now Puerto Rico has to shut down on that because they haven't the water to spare. The situation as to recreation is extremely difficult and we are certainly going to do all we can in Puerto Rico with such funds as we can get down there to help out.

CHAIRMAN PARRAN: Is there any further report? If not, I am sure all of you join with me in thanking Mr. Taft very much for the contribution he has made. (Appaluse)

The last item on the morning's program relates to medical problems in the administration of the Selective Service Act. Is Colonel Rowntree here? If not, I think he is represented by Colonel Richard H. Eanes, Assistant Medical Director of the Selective Service System.

... Dr. W. F. Draper took the chair .....

COLONEL EANES: Dr. Parran and State Health Officers: We all regret that Dr. Rowntree cannot be with us this morning. He had promised Surgeon General Parran to be present and it was with much regret that he had to delegate me to take his place.

It is my purpose to speak of a few of the matters that we in the Selective Service System have found to be of interest to the State health departments, and upon which these departments have given us a great deal of help.

The first of these will be venereal diseases. They have always been with us and are always troublesome in times of mobilization. This time is not an exception; it is felt, however, that with our modern knowledge and public

enlightenment we shall come nearer now to a happy solution than ever before in history.

In some of the States, particularly those of the South, where the Negro represents such a large percentage of the population, syphilis has caused one of our troubles. Young Negro men are being found with positive serology. Of course, many of them have no history of syphilis. Such Negro men in one State represent 29 per cent of those examined, and this percentage varies anywhere down to something under 20 per cent in the different southern States. At the present time the physical requirements for the Army exclude men having positive serology, for it is felt that a very large percentage of these men need treatment and the task is too great for the Army to undertake when there are so many things to be done. This requirement perhaps will be changed. The necessity for this change is hardly upon us yet, but it will not be long in coming, for these men are receiving treatment and a large percentage of them will never reverse their serology. If they are adequately treated and none of the sequelae of syphilis are recognizable, it is believed that they can do service. There has not yet been need of a definite statement from the Army as to what it will consider adequate treatment. It is proposed that this be determined, and that recommendations be made to the Army to accept these men as soon as some proper clinic or doctor is in a position to issue a certificate of adequate treatment and the registrant is properly reclassified for service.

It is felt that little trouble can result from the few cases of cerebro-spinal syphilis not discovered in this class of cases because a spinal tap is not made. It has been ruled that a man cannot be forced to undergo spinal tap unless he volunteers. There have been one or two instances of men who claimed exemption from service on account of cerebro-spinal syphilis when there was no evidence of clinical manifestations and the blood was negative.

In these cases the Army has ruled that it was incumbent on the individual to prove by submission to spinal fluid examination that there was evidence of his alleged condition; if this was not done he was inducted.

There will be a few men whom we consider really dangerous, who will get by and be inducted. I refer to the individual recently infected who is receiving treatment and either has never had a positive blood or has had a reversed serology about the time he is called for service. If he, in his ignorance or in order to hide his condition, enters the service without making his condition known, there is everpresent danger of a relapse. These are the men, who, while perhaps few in number, give trouble if inducted. You, as public health officers, will perhaps have occasion to discover when such an individual has been inducted. If so, it is asked that you advise the Corps Area Surgeon giving all details of diagnosis and treatment. With this information as a basis, a syphilitic register can be started for the individual and adequate treatment completed.

In a few places there has been a little confusion in reference to having serological tests done for the local examiners. This has been occasioned largely by misunderstanding. No money has been set up by Selective Service for this particular examination but State health departments have generally cooperated to the fullest extent in this work. Where they have not had proper funds, the Public Health Service has signified its willingness to assist in every way possible, and it is with their funds that much of the work has been accomplished. It is believed that the Public Health Service is holding itself ready to go on with this work in helping Selective Service. In a few of the States the local physicians have complained of delay in getting their serological reports returned in time for the scheduled induction of registrants.

This has caused trouble in two States where the examining physicians felt justified in ordering the tests made privately. They are now confronted with the bill from the private laboratory.

Gonorrhea has been giving some trouble. At Chicago we have been informed by Dr. Bundeson that an infection can be purchased for the express purpose of avoiding selective service. In Alabama there are many new, acute, recently acquired cases found at the induction station, these principally among Negroes of the rural areas. The authorities in Alabama do not believe that their Negroes are purchasing these infections, but that they are purely accidental and the result of the celebrations incident to the prospective departure of a member of the community. In other places the condition is not so serious, but with our modern treatment of chemo-therapy it would seem that we are almost in a position now to annihilate this infection completely.

Recently at Montgomery and at Richmond I sat in on conferences in which it was proposed that a close liaison be formed between all of the medical functions pertaining to selective service and induction and the State health authorities, a liaison whereby the State health authorities would be informed almost immediately of any infections coming to the knowledge of those connected with selection and induction. When these plans are written up and put into operation, the State health authorities, working in some cases with the Public Health Service, will arrange the treatment of the individual in accordance with the laws of the respective States, while at the same time they will ferret out, if possible, the source of infection.

From the general picture of distribution of gonorrhea as seen at Montgomery a prediction was made that Mississippi would soon begin to find an increasing number of cases. Unfortunately this prediction is being fulfilled according to a telephone conversation on Monday with Major Long, the State Medical Officer of Selective Service at Jackson, Mississippi.

I am one of those who believe that venereal diseases belong to the group generally classified as communicable diseases, and that as such they should be handled from a public health standpoint in the same general manner as other communicable diseases. It is a big field and requires energy, judgment, and knowledge on the part of those interested in completely obliterating this menace from society.

Tuberculosis is the third subject I would like to discuss. Unfortunately we find that the new X-ray machines for the detection of tuberculosis are not being used at all of the induction stations of the Army. Many X-rays are being made prior to induction, however, some through the facilities of the Public Health Service, some at Army stations, and others as the result of public-spirited organizations. To date, our rejections for tuberculosis are hardly as high as we expected them to be, judging from the 1917-18 rate. We had naturally thought that the use of the X-ray would uncover many types of cases that were not discovered in World War I and that even an increase in the rate per 1,000 would not be a discredit to the good work that has been done in this field. It is too early to be certain or to try to quote figures. Of course, the true picture cannot be determined until all reports are in, including those on the discharge from the Army of inductees on certificates of disability. Of course, such a picture is still far off. The local examining physicians are now required by the State laws to report tuberculosis when they make such diagnoses.

Prehabilitation is a subject in which Dr. Rowntree is extremely interested. It means to him the voluntary correction of remediable physical defects which a prospective selectee discovers himself as a result of his interest in his

own physical well-being, both for his personal benefit and for his fitness to serve in the national emergency. At the University of Minnesota a most excellent and practicable plan is already in operation. This has been reported to you, I know, by Dr. Diehl. We, of the Medical Division, are hopeful that this plan will be so advertised that it will spread to the campus of every university in the United States and that industry and others will also fall into line. A series of articles in very understandable language is being published in The Journal of the American Medical Association. It is hoped that these articles will be copied by less exclusive journals and will reach the population which does not have the benefit of college or industrial guidance so that young men learning the requirements will measure themselves, and, when they are not certain that they meet the requirements, will seek advice and assistance. It is believed that the United States Public Health Service and the State health facilities will naturally be brought into a part of this, for it will be necessary to refer to some public agency those of the population who are not financially able to meet a private obligation with their family physician or dentist.

Likewise, those cases classified on examination as I-B, subject to limited military service, who have conditions which are remediable should have pointed out to them the nature of the condition and the means whereby it may be corrected. After an analysis of a group of these I-B cases it was determined that the majority of them could be rehabilitated and rendered fit for Class I-A.

It would seem of limited value simply to inform some individual that he does not meet the physical requirements and that he should have his remediable defects corrected, unless we know that such action is within

his means or unless we tell him just where and how he is to get the necessary remedies. I can conceive of a plan both for prehabilitation and rehabilitation whereby the local board chairman has in his possession a list of all health facilities in his vicinity which can be made available for this work. It is in the preparation and maintenance of this list that State health officers can particularly interest themselves so that the members of the local boards can advise with assurance that all selectees needing such assistance will receive the best help obtainable.

The subject of medical personnel is of tremendous interest to all of us. Deferment by groups under the Selective Training and Service Act of 1940 was explicitly prohibited. We have a large body, more than 22,000 persons in these United States, who are seeking an education in the medical profession. Of these, some 5,000 graduate into the medical profession each year. Of this 5,000, somewhat more than 3,000 are needed for the replacement of the normal attrition in the medical profession.

The Army has, or will have within a very short time, more than 7,000 doctors of the medical reserve corps on active duty. These men have been called from civilian life, in accordance with the law, for a period of one year, and at the end of that year, according to the present Act, they will have completed their obligation of military service to the nation. It is estimated, however, that about 50 per cent of them will be willing to continue for a longer period of time. We therefore see that 3,500 who are fit for active military service will be needed each year for replacement in the medical corps of the Army. It has also been estimated from experience that only about 75 per cent of those graduating into the profession are fit for active military service, the remaining 25 per cent being women, physically unfit, or persons with excusable reasons.

So we see that the 3,500 who come into the profession each year and who are physically fit will be needed for military service immediately after the completion of their basic medical training. It is estimated in the Surgeon General's office of the Army that their present pool of reserve officers fit for active military duty will be completely exhausted before the end of 1942, leaving them dependent upon the medical graduates of 1941 and the succeeding years.

It has been asked why the Army requires doctors to an extent so out of proportion to the supply for civilians. It is true that the Army is requiring a little more than six medical officers per thousand of its population, while the civilian population gets along with something less than two doctors per thousand. We must bear in mind, however, that the duties of a medical officer in the Army are quite varied and cover many things to which a civilian doctor does not have to give much time. Our people are pension-minded and unless medical records are kept, full and complete, they leave much to be desired for the pension clerks of the future. Then, too, soldiers with minor ailments are a complete nuisance in the barracks. They are hospitalized for conditions for which a civilian would never think of seeking hospitalization. Sanitation is another duty requiring much time and effort. I have not mentioned the needs of an enlarging Navy, Public Health Service, and Veterans' Administration. Their needs are as urgent, though not so great in numbers, as those of the Army.

From this, it is apparent that we must maintain the supply of doctors at least at the present level. The subject has been given much thought at national headquarters of the Selective Service System and, on the basis of the facts presented by the Medical Division and by the Office of Production

Management, the Director of Selective Service will shortly issue a statement to the State Directors pointing out the supply and demand of members of the profession and the desirability of maintaining the national health, welfare, and safety. The deferment must be made on the merits of the individual case and the decision rests with the local board. To assist them in their work, the deans of the medical colleges have been advised by their committee for study of this problem that each student receiving a questionnaire should present to the local board complete facts supported by a statement from the dean of the medical college, wherein the facts in reference to the academic standing of the particular student are stated and recommendation is made for his deferment or non-deferment. It is also thought desirable that the president of the college or university authenticate this statement of the dean. It is believed that this will result in the deferment of those who properly should be deferred to maintain a supply of doctors sufficient to meet military and civilian requirements.

Now that we have disposed of the medical student problem, I shall endeavor to tell you something about young doctors. The Surgeon General of the Army considers the initial internship year as a part of the basic training of a doctor, and in this all of us thoroughly concur. I mention it simply to clear the field for action. There is no limit to the peacetime procurement objective of medical corps reserve officers. Graduate students or young doctors who apply for a commission in the medical corps reserve and who meet the physical and other qualifications will be given a commission in that corps. This automatically takes them from the jurisdiction of Selective Service. It has been arranged that such young medical officers who are serving their initial internship year will be carried administratively in a War Department pool, subject only to the advisory

control of the Surgeon General, and that they will not be called to active duty during that year of internship. The Surgeon General desires only doctors with a completed basic medical education. All young doctors and those about to graduate may apply immediately for a commission in the medical corps reserve. This can be done through the commanding general of their respective corps areas. The Surgeon General and Selective Service are not interested in making secure for doctors an internship of more than one year. It is felt that such extended internships can be arranged after the year of active service has been completed.

It has been found that a situation very similar to the one described above in regard to the medical profession likewise exists in the dental profession. This is hardly the place to say much in reference to this subject, for there are other angles to it which are still being studied. I simply mean to mention it so that you will know that it is not being overlooked.

It is desirable now that we examine a few slides to be shown on the screen to help us visualize a few of the things revealed by the operation of Selective Service.

The first slide shows the relative importance of the ten principal causes of rejections at Selective Service local boards and at the Army induction stations.

Based on the latest information available, the Selective Service local boards are classifying as available for general military service, Class I-A, about 68 per cent of those who are being physically examined. Approximately 12 per cent are being placed in a limited service classification, Class I-B, and 20 per cent are being disqualified for any military service, Class IV-F. Of the 68 per cent that are being sent to the induction

stations, about 13 per cent are being rejected as unfit for general military service. Usually borderline cases are given limited service classification.

This means that approximately 40 per cent of all men examined by Selective Service local boards are being rejected for general military service. About one-half of these, or 20 per cent are in the limited service classification, the major portion of whom have defects that are remediable.

This slide shows that of the 32 per cent who are rejected after being physically examined by Selective Service local boards, 18 per cent are rejected for teeth, 10.6 per cent for eyes, 10.1 per cent for cardiovascular defects, etc. It also shows that, of the 13 per cent rejected at the induction stations after passing examinations by local boards, 19.3 per cent are rejected because of teeth, 13.3 per cent because of eyes, 10.5 per cent because of mental and nervous defects, etc.

The second slide shows a breakdown of the broad classification of major defects for those registrants being placed in limited service classification, Class I-B, and those who are being totally disqualified, Class IV-F. Of significance is the fact that the eyes, teeth, hernia, and conditions of over- and under-weight account for a considerably higher proportion of the total number of defects in the limited service classification than in the disqualified classification.

I am sure that figures which will also be of tremendous interest to the group are those showing the relative importance of gonorrhea and syphilis. Tuberculosis has been classified in conjunction with "other defects." "Obvious defects" refer to those registrants who were rejected by Selective Service local boards due to obvious physical or mental disability which permantenly disqualifies the registrant for any form of military service.

This study was based on the major defect only, with the exception of the generally delinquent classification which included three or more disqualifying defects or many non-disqualifying defects which when considered in the aggregate were sufficient cause for rejection.

CHAIRMAN DRAPER: We want to express appreciation to Colonel Eanes for his very interesting presentation. I am sure that he will be glad to answer any questions that anyone may have to ask him, and to listen to any discussion that anyone would care to offer on this.

DR. J. LYNN MAHAFFEY (New Jersey): Dr. Draper, in one of our counties in New Jersey 45 people were examined. Out of the 45 persons examined for military purposes, 25 were accepted at the first examination. Between the time of the first examination and the second examination, 16 of the 25 developed acute gonorrhea, were sent home on temporary deferment, and were told to report back for service after they were cured.

It seems to me with such a program those men would infect a great many people in their home districts. If they so desired they could stay out of employment or out of war service as long as they desired to do so because of the fact that they could become reinfected. We think they ought to be kept in service, especially in the case of gonorrhea, because the length of treatment required for cure is very short.

COLONEL EANES: The question you bring up is not one for Selective Service to decide. The question as to whether men will be accepted with acute gonorrhea belongs to the War Department. There has been discussion along that line, and the conditions which may arise as the result of this rejection, which you describe, are well recognized in a number of places, and this was the reason for the conference at Montgomery, Alabama. It was because of this situation that the suggestion was made that all of

the Selective Service people contact the State and county health officers just as quickly as possible so as to get these men under treatment with sulfathiazole.

The Richmond problem was not so acute as that in Alabama, but nevertheless it was given considerable thought, and as the result of the conferences I believe that the situation will be taken care of in those places.

I can't tell you what will be done by the War Department in the future in reference to taking into the Army and treating acute cases of gonorrhea. At the present time they are excluded because the Army feels it has plenty of work without that, and that it is an obligation of Selective Service to deliver those men free of infection.

DR. WILLIAM B. GRAYSON (Arkansas): In my State the local boards have told the selectees that upon obtaining a negative serology they should report back and be inducted into service. We do not have facilities in each and every county and some men have reported to private practitioners. After some six, eight, or ten weeks of treatment, upon securing a negative serology, the local draft board then inducts them into service and the Army accepts them, and, as I understand, renders no further treatment. I think this procedure gives the individual a lot of false security, sometimes leading him to believe, through his own ignorance, that he is cured of the disease when he isn't.

COLONEL EANES: I agree with you absolutely. I mentioned it in this paper because I feel very strongly on that particular point. I don't know how we are going to overcome that except for all State health officers, all county officers, or all doctors who have knowledge of such things going on, to notify the corps surgeon as quickly as possible and let him inform the surgeon who has immediate jurisdiction over the men concerned. I

personally am much more afraid of the man who has a negative serology after a short course of treatment than of the Negro who has a positive serology, who possibly has had for many years, and who perhaps will continue to carry it, no matter how much treatment you give him, for the rest of his life. I believe they should be adequately treated before we turn them loose.

DR. GRAYSON: At the conference in Kansas City about which Mr. Taft spoke, a Committee on Health was appointed, consisting of Dr. Fullerton of the Service, a woman from the Department of Agriculture, and myself, and among other recommendations that we made to this group was that these people be given at least a year's anti-syphilitic treatment before the local board would refer them for induction. Now, whom this committee's report reached or whom it went to, I don't know, but that was the opinion of our group.

COLONEL EANES: That is exactly according to my line of thought.

DR. WALTER L. BIERRING (Iowa): I would like to ask Colonel Eanes what importance is attached to the intensive treatment of syphilis.

COLONEL EANES: I am afraid I can't answer that. So far we have not considered it in Selective Service. I feel that it is still too much in the experimental stage, and, while it may be the answer at some time in the future, I am fearful of it at present. No thought has been given to it whatsoever. It has been mentioned but we haven't discussed it. We are still adhering to the old lines of service.

DR. ROY LEON CLEERE (Colorado): Do the Selective Service Boards assume any responsibility as far as the rehabilitation of those rejected is concerned?

COLONEL EANES: No responsibility whatsoever has been assumed unless it be just as a local physician would assume the responsibility

of advising one that he is below the physical requirements. The question is under discussion now in national headquarters, and, while I wouldn't like to predict it, it is possible that a responsibility will be placed on the local board to the extent that the proper advice will be given to the rejected registrant as to how he can rehabilitate himself, and that he will be called back for a reclassification after a certain time has passed. Don't take that as positive information. I say that it is under discussion at national Selective Service headquarters. It would be premature to say anything definite about it.

DR. FRANK C. CADY (U. S. Public Health Service): Colonel Eanes made the remark that with the advent of dentists on these examining boards the large percentage of dental rejections would be materially reduced. I wonder if he would amplify that statement a bit.

COLONEL EANES: First of all, I might say that the Surgeon General recently issued circular letter No. 26 on the dental requirements as described in MR 1-9. To you gentlemen who don't recognize what I refer to, MR 1-9 contains the mobilization regulations of the Army, and describes the physical requirements for induction. The dental section of that is quite rigid and the Surgeon General recently issued circular letter No. 26 which is an interpretation of those dental requirements; this letter liberalizes the wording of MR 1-9 considerably.

National headquarters of Selective Service has on the press at the present moment their Medical Circular No. 2, Dental, which will go out to Selective Service boards. It is in part a copy of circular letter No. 26 of the Surgeon General, but it contains still more explanatory material. We felt that with this interpretation made from Washington, the dentists would be able to use more flexibility in their judgment of dental conditions.

When physicians undertook to examine the teeth to find if they met the physical requirements, they were, so to speak, encroaching upon another profession. I don't mean to say that doctors can't do it; they can. But many of you have given very little thought to that, so it is our feeling that with the dentists actually operating in these boards, and with the interpretations which have since been made for them, more men will be accepted with some dental defects who would have been rejected under the former system.

DR. WILSON C. WILLIAMS (Tennessee): Exclusive of the venereal diseases, we have been rather concerned about getting information as to the causes of rejection of men because of preventable conditions. In discussing the conditions under which the medical examinations might be studied we were told by our State Director of Selective Service that this information could be made available, or that through the State Selective Board we could have it transposed to punch cards upon approval of the National Selective Service Board.

Some weeks ago the formal request was made for permission to see that this was done in order that we might later analyze the result of examinations by regions and by types disqualifying physical condition. So far we have had no reply. Approximately 15,000 of the examination records have already come in to Washington. They are still holding a number of them, some eight to ten thousand, I believe, pending a reply to that particular query. I discussed this with the State Director of Selective Service before I came up here, and he asked that I communicate with the proper official in the National Selective Service Board to see if he could not get permission to have these examination results coded and

punched in order that we might make our own study within the State and utilize the information in planning certain phases of our public health program in the future.

With whom should I communicate with reference to getting approval and getting the State Director notified that that particular plan is approved?

COLONEL EANES: I am going to ask you to visit the Medical Division. I believe that is a question we had better discuss there. If you can find time to come and see us over at 21st and C Street, we will be glad to talk to you. Come and see me in room 623 any time this afternoon, if that suits you. There is quite a bit of discussion along the lines that you mention.

CHAIRMAN DRAPER: Is there any further discussion? If not, we thank Colonel Eanes for his information.

Dr. Mountin, do you care to make some committee assignments or announcements?

DR. J. W. MOUNTIN: I see that we have now reached the time for recess. There is just one statement I have to make with respect to committee assignments, and I would like, with your permission, to amplify that this afternoon. Inasmuch as the work of Conference committees is very important and in my opinion has not been done uniformly well in previous conferences (and that is an opinion shared by your Secretary, Dr. A. J. Chesley), we ought to go into the committee work a little more fully than I can at this time.

In planning the program, Thursday has been set aside for committee meetings. That allows ample time -- all day for that matter -- to meet under favorable circumstances, and to give careful consideration to a number of topics which I will enumerate this afternoon.

I think the committee membership is known to all. You have received a covering circular letter. I would ask each chairman to announce this afternoon, sometime before closing, where he wishes to meet with his committee. It is my opinion that it may be more satisfactory to meet at the different hotels where you may be stopping, although if you wish to use the facilities of this building we will be pleased indeed to have you here.

I wish to take up the committee work a little more fully this afternoon.

CHAIRMAN DRAPER: Without objection, the meeting will recess until one-thirty this afternoon.

... The meeting recessed at twelve-twenty o'clock ...

TUESDAY AFTERNOON SESSION

April 29, 1941

The meeting was called to order at one forty-five o'clock p. m. by the Surgeon General, Dr. Thomas Parran.

CHAIRMAN PARRAN: I referred this morning to the welcome we wish to extend to the new State health officers who have been appointed since our regular meeting a year ago. I hope that those whose names I call who are here will stand so that they may be recognized: Arizona, Dr. Jack B. Eason; Delaware, Dr. Edwin M. Cameron; Florida, Dr. William H. Pickett; Illinois, Dr. Roland R. Cross; Indiana, Dr. John W. Ferree; Nebraska, Dr. Arthur L. Miller; New Mexico, Dr. James Scott; and West Virginia, Dr. C. F. McClintic. We are very glad to welcome these gentlemen.

Dr. Mountin, will you continue where you left off this morning with reference to committee assignments and then open the discussion of community health services and facilities?

DR. J. W. MOUNTIN: Doctor Parran, Members of the Conference: As I stated this morning perhaps the most important item on the program of these conferences is the committee deliberations and reprots. I should qualify that and say they should be the most important. They have not always been so in the past. Perhaps you realize the significance of the relationship that has developed between the State health departments and the Public Health Service. It has become such a matter-of-fact scheme it is taken for granted, but when I describe this relationship to other agencies of the Federal Government, they don't quite believe me. They don't think it is possible really to develop a program and a system of regulations for carrying out a program in a give-and-take sort of meeting such as we have here

today. This year in talking with Doctor Chesley we went over the matter rather carefully and had a rather frank discussion; we arranged that more time be given to the consideration of the committee reports, and their preparation.

I wish to correct a misstatement I made this morning. Originally we had expected to devote the entire day Thursday to the preparation of committee reports. Without my knowing it, there has been a change in plans because the Canadian health officers have to return and, therefore, the State and Provincial health authorities will discuss their reports that afternoon. Therefore we will have only the morning for the preparation of reports. Friday, however, or as much of it as may be necessary, will be devoted exclusively to the consideration of the reports by the committees whose names I shall now read. (Dr. Mountin read the list of committees and committee members. The list is given in the Appendix.)

Another suggestion which grew out of our conversation with Doctor Chesley is that we attempt to formulate ahead of time the items for discussion. I think the various chairmen have communicated with their members in respect to their suggestions. In other words, it was intended that suggestions should come from the field and from the central office.

With respect to financial grants-in-aid, it seemed to us that the committee might again clarify the scheme of justifying quarterly payment so as to prevent the accumulation of unexpended balances. That was discussed at length during the last Conference. Regulations were written in accordance with the report of the committee. These have been distributed, but there still seems to be confusion as to how the unexpended balances are going to be adjusted. Some of you have even insisted that we got a wrong

interpretation of what the committee intended last year. I have checked that with Dr. Arthur McCormack and he assures me our interpretation is correct, although I think you would like to have word directly from his committee.

Revision of the allotment formula has been suggested so as to provide less on the basis of population and more on the basis of special health problems. The situation which precipitated that point was the possibility of adjusting programs and funds so as to meet the special problems of defense areas.

The next question which you will want to discuss, or at least be prepared for, is the effect of the 1940 population and income figures on State allotments. You understand that allotments are made on the basis of a formula agreed to. According to the 1940 population figures, some of the States have gained and others have lost. Another criterion is the per capita figures. The Department of Commerce has given out new figures on per capita income which will affect the allotments to some extent. There has been some change in the mortality figures. Therefore, if we adhere rigidly to the present formula some of you will get more than you got last year and others will get less. So be prepared for a change in your allotments -- we cannot, even if we so desired, freeze the amount at what you are now getting.

I would ask, however, that the Committee on the Social Security Program also consider emergency health and sanitation needs, giving particular attention to the adjustment of resources to the programs of defense areas, the use of emergency health and sanitation funds, and whatever other problems that seem to have arisen in connection therewith.

The Committee on Hospitals should consider especially how we might administer, if we have a part in administering, the funds which will become available under the Community Facilities Bill. I would ask this committee especially what should be done about the rejected draftees, those rejected on account of physical defects.

Among the questions which the Committee on Interstate and Foreign Quarantine might discuss are the codes that have been developed by the Public Health Service, and the need for additional codes, if any. Doctor Creel wishes to place before you some ideas he has as to how an effective plague control program might be developed. Doctor Fullerton has been giving special attention to accomplishments, or lack of accomplishments, in sanitation of common carriers, and he wishes to place such matters before your committee.

I think that the Committee on Professional Education has already met. A number of items were considered which should come up; therefore, I believe this committee has its agenda pretty well in mind.

The Committee on Records and Reports has concerned itself to date primarily with progress reports, that is, reports which describe activities. Until now, no committee has given very serious consideration to fiscal practices and procedures. We would like the Committee on Records and Reports to expand the scope of its interest and responsibility to include fiscal affairs as well as records and reports describing activities.

These and other suggestions are written out, and I will give copies to the several chairmen. Now I shall begin on the first item of the program for this afternoon, namely, the discussion of health and sanitation activities in defense areas.

First of all--what is meant by a defense area? That is something rather easily understood, but difficult to define. Perhaps it is just as well that we do not attempt to define it too rigidly.

One type of defense area, of course, is obvious, and that is the place to which the armed forces go for purposes of training or maneuvers. A second type of defense area rather easy to describe is that located around a well defined government industry directly associated with the manufacture of war materials--for example, the arsenals and places of that character. Then there are areas around what we call the essential private industries, those having large contracts for materials of war. Some of these may be new industrial communities while others may be communities which existed previously and in which facilities have been expanded.

Responsibilities of civil health agencies to these different types of areas vary somewhat. Around strictly military reservations, of course, the job is protection of the health of soldiers as it might be affected by contact with the civil community. In the industrial area it is the industrial worker with whom we are primarily concerned.

An aspect of the general problem upon which I would normally dwell at length is the breadth and content of the program contemplated as the Public Health Service's contribution to national defense. That has been discussed extensively this morning and there is no need for elaboration. You heard the suggestions of the head of the Federal Security Agency; the Assistant Coordinator of Health, Welfare, and Related Activities described the problems as he saw them; and the Surgeon General not only gave his views, but in addition he described in detail what is being done in England.

The English are somewhat on the defensive in the sense that they are being attacked, whereas we are preparing for whatever might happen, and to a great extent are not being disturbed by any outside influence in that preparation.

It was clearly brought out in all of these discussions that health departments, in addition to do their old-line, normal activity, should concentrate on the problems of defense. In addition to that, they should embrace this larger opportunity to be of service in the general defense program, even if it means some curtailing of what would normally be done in peacetime. Civil defense likewise was described to you by Doctor Crabtree, and your role in that field was set forth quite clearly.

I might say that in many defense localities we must drop back twenty-five or fifty years for the basis of the public health program. We are confronted with boom-town conditions, frontier conditions, in which the very elemental functions of a health department are most needed. What I mean is just ordinary sanitation--sanitary methods for disposal of excreta, a safe water supply, protection of the food supply, and drainage. Those are the really pressing problems in many of the defense areas and we have not as yet approached them in an aggressive manner. Just talking about them isn't going to do the trick. Some dirt has got to be moved. Some plain clean-up work must be done, and I would say vigorous law enforcement. When I speak of law enforcement, I am speaking of law enforcement such as was known twenty-five or fifty years ago; law enforcement as it was exemplified by some of our illustrious forebears. I am thinking of Doctor Dowling in Louisiana, Doctor Young in Chicago, Doctor Hasler in San Francisco, and Doctor Dixon in Pennsylvania.

Conditions would be much better than they now are if some scheme of licensure were in effect which was applicable to rural and unincorporated areas. A large part of the developments of which I speak are out in the open country. Counties as a rule do not have ordaining power. No agency has power to determine the use of property. Zoning, for example, is unheard of, and as a result the usual course is to wait for something to happen and then hail the person into court for maintaining a nuisance--something he should never have been allowed to do in the first place. No one would think of establishing a "hot dog" stand right out in front of the Public Health Service Building on Constitution Avenue, yet they are established at will in defense areas.

I suspect, too, that the health departments will actually be called upon to operate facilities. Traditionally, health departments have shunned operation — I don't know why. They seem to regard themselves as educational and law-enforcement agencies, but mostly educational; in other words, they are continually finding out what ought to be done and then telling somebody else how to do it. Situations are now confronting us which I believe will make it necessary for them to operate facilities. I have in mind hospitals and health centers, and also instances in which the operator of the water plant will be called away for military duty so that an engineer of the health department will actually operate the water plant. We did it, I recall, in '17. I have in mind the same emergencies in connection with sewerage plants. In other words, I believe we are now at the stage where we will have to perform actual services instead of simply talking about them.

It is distressing to find how restricted health departments are in what they actually have legal authority to do. Actually, there are a number

of areas in which no public agency really has authority to operate a hospital. Very few States have basic legislation regarding the formation of hospital districts. In some States, cities and counties cannot combine to operate a hospital. One or the other may be permitted to do so, or they may contract with each other for the performance of services.

If water supply facilities are to be developed in some of these unincorporated areas which I have described, who is going to build them? Who will be legally and fiscally responsible for them? Who is going to issue the bonds? Who is going to collect the revenue and liquidate the debt? These points just haven't been thought of. No, I had better not say that -- they have been thought of. You may not recall now that I wrote each of you a letter about last January in which I called your attention to the fact that health departments should review legislation on the statute books applicable to the State and to the locality with reference to their authority to do the things I enumerated. I was very much chagrined to find so much unanimity in the replies: "Our laws are quite adequate. We are prepared to do everything we have been called upon to undertake so far and are quite satisfied we will be able to meet whatever situations arise in the future." That is about the sort of reply I received.

Because of time limitation I am going to close by saying a word about the efforts of the Public Health Service to help out through the use of emergency health and sanitation funds. As you are aware, an appropriation of $525,000 was made available for the period March 1 to June 30 of this year. We endeavored to secure such an appropriation last fall but it got lost in the legislative jam and did not become available until

March 1, 1941. The same monthly rate of expenditure has been recommended by the budget for the next fiscal year, but we are hoping that it may be increased several times. Emergency health and sanitation in defense areas, of course, do not encompass the broader program discussed this morning.

This appropriation, let me say, has been made to the Public Health Service. It is not a grant-in-aid. It does not follow the pattern of Title VI of the Social Security Act, nor does it follow the pattern of the old CWA appropriation with which some of you are familiar. This money is appropriated to the Public Health Service and must be spent through the regular fiscal and administrative structure of the Federal Government. It will be used primarily for the employment of personnel. That course is being followed very largely on the basis of your suggestion. You have told us in correspondence and by conference, and even in your meeting last fall, that your great need was personnel. So we have undertaken the job of recruiting personnel and giving them a short period of orientation which has already been described. I will not go into that.

Let us be clear on this point -- these people will be assigned to States on the basis of availability and the most emergent need at the time of assignment. We will be guided by your suggestions, the recommendations of our district offices, and whatever judgment we are able to exercise here in the central staff. You will have to bear with us at least in the beginning when the numbers are few and the problems are many. Later on I think we will be able to meet even the lesser needs; at least I hope so.

Persons being recruited are of professional grade. They are doctors, nurses, engineers, and laboratory workers. We are not recruiting persons below professional grade. That does not mean that you should not employ persons below a professional grade for nontechnical jobs, but we believe you should do it with your State or local funds.

These persons will be assigned to localities selected on the bases I have just described, they will be subject to your direction, and they will be responsible to you and to the local health officers. So far as your relationship with these persons is concerned, the scheme will be no different whatever from the procedure you are now following under Title VI of the Social Security Act, except that they will be paid directly by a government check.

There are two qualifications which I want to make. Such personnel must be assigned to defense areas and be prepared to accept changes of station. In other words, you may have these people taken away from you and assigned to another place where the emergency is greater. We hope that will not be necessary, but it might happen.

Lastly, I hope that you will not get the implication that the Public Health Service is taking over the job. We are neither accepting the full fiscal responsibility nor the administrative responsibility for the medical and health aspects of national defense. We expect to go forward with you on the same cooperative basis that has been followed for these several years, especially since the enactment of the Social Security Act. We want the partnership to be of the same character. We expect to make recommendations to you and you must feel free to make recommendations to us.

In every instance your participation is essential. Above all, you have the immediate moral and administrative responsibility. The community should contribute fiscally, even if it is only a token appropriation in the beginning. Gradually as the tax structure is built up in these communities, a larger measure of community support is expected. I am told that the payroll in a cantonment is upwards of a million dollars a month. A good share of that million dollars is spent right in the

locality. In areas around many defense industries the payroll is perhaps in excess of that, and the great bulk of it is spent right in the community. At the moment these communities may not have the tax base upon which they can draw for the support of enlarged community services, but certainly as time goes on they should acquire resources with which to support a large part of this program. When the emergency is over, some parts of the health organization may be liquidated, but I suspect that in a good many communities the development will be sustained. (Applause)

CHAIRMAN PARRAN: Thank you, Dr. Mountin.

Dr. Mountin has invited questions and discussion.

DR. JOHN W. FERREE (Indiana): From what source may we expect to have funds for those areas that have no available funds to pay for personal services not of a professional grade, such as garbage collection, for example? Is that going to come from some other source?

DR. MOUNTIN: That problem has been a troublesome one. I think I have in mind the same town you do; it has been publicized quite a bit. We have endeavored to interest WPA. I have been told that the WPA can under certain emergencies perform limited essential community services, although they prefer to do something in the way of construction.

It is not contemplated that the emergency health and sanitation fund of the Public Health Service should be used for that purpose. Expenditure for such purpose is not specifically prohibited, but it certainly was not in our justification of the appropriation.

In the Facilities Bill, operation is mentioned as one of the features of the bill, but I think the form refers to the operation of the facilities erected under this legislation rather than to the support, we will say, of a garbage collection system. Frankly, I don't know how to meet that situation through Federal funds now available or which may

be made available. I rather think that the community will have to improvise some sort of scheme. Would it be possible for the counties in your State to perform the service?

DR. FERREE: No.

DR. MOUNTIN: It comes right back to what I said in the beginning. The country has been caught in a situation in which no one contemplated carrying on community services in open country, and it was a serious defect in our whole legal set-up.

CHAIRMAN PARRAN: May I ask the gentleman from Indiana if the people who are served by garbage removal are not able to pay fees to cover the cost of service?

DR. FERREE: They have objected strenuously to it because a lot of them feel it is no obligation of theirs. They didn't ask for the service and don't propose to pay for it. We have a man down there but he has been gouging them and raising his price continually until they have become dissatisfied with that sort of set-up. That is the way it has been handled in the last two weeks. Furthermore, they have been very reluctant to consider the expenditure of any State defense council funds for it. Summer is coming on and this matter becomes a serious problem.

CHAIRMAN PARRAN: I should be very reluctant to use Federal funds to pay for the removal of garbage from boom areas. Houses and stores and other places which are served are, in my view, perfectly able to pay a reasonable cost for that service, which I would assume to be organized by the State or local health department, with the help of our personnel.

DR. WALTER L. BIERRING (Iowa): Would it be possible to obtain a nutritionist through this source? I mean some one who would be a State nutritionist, possibly associated with a State committee on nutrition.

CHAIRMAN PARRAN: I should say that Title VI funds are available, and I assume -- Dr. Eliot can correct me -- that Title V funds are available for that purpose. I doubt that the emergency defense funds are available for State-wide nutrition service.

DR. MOUNTIN: No, we didn't list any in the justification.

DR. ARTHUR McCORMACK (Kentucky): Dr. Parran, I find myself still confused about this matter of assignment of personnel. The suggestion was made to us that we select some specially qualified key personnel to be used in the defense areas. They would be assigned to us for those defense areas. Now Dr. Mountin informs us that this may be the case and it may not; that they may be taken away from us. We can't lose any more, and under the circumstances we can't use any of that key personnel in the defense areas at all unless you send some one to us who is approximately as good. I don't think you have any one as good available. We are simply going to fall down in the defense areas, because we can't play ball if we are going to furnish all the members of the team on both sides.

I have in mind the health officers. Let's make it specific, because I know this is happening to many of us. I have had a health officer who has had seven years of experience. Dr. Merriweather is particularly eager to have him assigned to Campbell County where we have no health department and where the State will have to take over the whole function. He has finished a year's course at Harvard. They have needed him for three months. They won't need him three months from now. The thing is going to pot rapidly.

We have one of our assistant engineers whom we want to assign for the whole defense area. Nobody is going to come in who in a year can learn what that man knows about the geography and biography of the situation. I am interested in meeting the problem in California, but

if we sent him to California it would take him a year to find out as much as he already knows about Kentucky, and the man who comes from California to us wouldn't know anything about the specific situation for a year. Both of them would be useless during the first year of this present emergency.

Dr. Derryberry wants to borrow the assistant director of my Bureau of Public Health Education. I have been perfectly willing to loan some one person, but if five or six of the key people from my department were to be taken away to the defense areas we would be in a bad position. We are already poor and we would be left impoverished, because about the only thing we have is brains and we can't afford to lose any of them.

DR. MOUNTIN: I don't know whether I can answer your question with respect to a specific individual. I think I can enunciate some principles, however, upon which we have operated.

We have felt as though this money should be for the recruitment of new people. In other words, if we merely take over the salary of an existing employee, we will be contributing nothing to the personnel structure of the country.

DR. McCORMACK: Let me make that clear. We would get another man for each one of these men.

DR. MOUNTIN: Let me finish. Principle No. 1 is that we will get new people. The next principle is that we will do our best not to take people who are now employed in State or local health departments. We have honestly tried to follow that rule. Situations have arisen in which we could not do it since we were confronted with the Federal civil service law. When we wish to employ a person, we send a communication to the Federal Civil Service Commission requesting a register of persons

with certain qualifications. The Commission sends us the names of persons whom they have on the register. It has happened that certified persons are employed in health departments; unless we can raise an objection to the individual on the basis of his not having the qualifications he must be employed.

The individual can decline the position. He can decline twice without losing his status with the Civil Service Commission, but if he declines a third time he loses his Federal civil service status. That is the second principle.

The next question came up with regard to situations such as this: an individual is now employed in a State or local health department, he has Federal civil service status, and he can be certified to us. Would we employ him and agree to assign him back to the same State? So far we have not agreed to do so because we fear that with present funds we would very quickly have an organization fixed as to locality; it would not have the mobility that we believe essential for doing the job at this stage. Later on when we are more nearly meeting the situation, perhaps that would be an entirely feasible arrangement.

DR. WILLIAM B. GRAYSON (Arkansas): In the event that we lose our personnel either to the Public Health Service or to the Army, and we look around to do the next best thing and find individuals of good judgment who have some semblance of a background in health work, even though they might be above the nominal age limit of 35 at which we accept personnel now, would you, upon our recommendation, approve that type of individuals for appointments to be paid for out of Title V and VI Funds? In other words, where we have lost personnel and we reach out and get the next best person we can find, even though he might not measure up to our ideals, can we pay him out of those funds?

DR. MOUNTIN: I wish to elaborate a little bit on that question because it raises an issue with respect to the merit system. Qualifications were set up some years ago by the State and Territorial health officers which in most essential respects have been incorporated into merit system standards.

We would not wish to have you deliberately try to set aside any merit systems that have been developed, or to delay the establishment of such systems. I presume, however, that your merit system, if it does not now provide for it, can be revised so as to permit you to employ temporarily persons not on the register in order to meet urgent situations. In any event, you should operate through your merit system.

CHAIRMAN PARRAN: Dr. Grayson, Dr. Mountin says the answer to your question is "yes."

DR. C. F. McCLINTIC (West Virginia): It seems to me this is the best place to secure advice as to what we are going to do with reference to water supply and sewage disposal in these areas which are becoming thickly populated outside of incorporated city limits.

CHAIRMAN PARRAN: The answer is that if the pending Community Facilities Bill passes, funds appropriated under it will be available to build water supply and sewage disposal systems, hospitals, schools, etc. No money is now available in any appropriated funds.

DR. MOUNTIN: The money will be available through the Facilities Bill if it passes. You may still have a problem however, as to who is going to sponsor the development in these unincorporated areas. It will be necessary to organize some sort of a sewer district that can issue bonds or that can operate the system--and when I speak of bonds I refer especially to revenue bonds. There is going to be a question of operation and I doubt if the Federal Government will want to come in and do it entirely on its own responsibility.

DR. ARTHUR McCORMACK: Do you think we will ever be able to issue and sell bonds in a place that is only going to be used temporarily, for a few years?

DR. MOUNTIN: Revenue bonds, yes, that is bonds secured by the income from the facilities. Such income would liquidate at least a part of the loan.

DR. McCORMACK: You would have to make them pay 100 per cent if you are going to do it in one of these mushroom areas. You will have to pay for the facilities in the first year because they are not going to last longer than that, I hope.

CHAIRMAN PARRAN: Dr. McCormack is optimistic as to the length of the duration.

DR. ROY LEON CLEERE (Colorado): With regard to personnel, do I understand Dr. Mountin to say that personnel would not be assigned to a State for any definite period of time; that is, the period of time in which the personnel would be working in a State would be very indefinite?

DR. MOUNTIN: I would say for the time being, for the duration of the emergency, and until a more acute emergency developed elsewhere--if that is specific enough.

I am not being humorous or evasive, please understand. I can't do either. But we don't intend to be shifting these people around on a cribbage board. That isn't the idea at all. In all probability, if a person is assigned to a place he will continue to work there as long as there is a need for him. On the other hand, if you would take over the salary, or if the community would increase its participation in the budget, he could be released for outright local employment. I merely wanted to guard against developing a Federal corps that is fixed as to locality.

Please understand that we don't intend to be shifting people hither and yon merely to keep them mobile.

DR. ROSCOE L. MITCHELL (Maine): The recruitment of professional personnel has been rather difficult with us, and recently a couple of our nurses have given us notice that they are going into the Public Health Service under this recruitment. The recruitment of personnel has been almost a continuous emergency problem with us, and I wondered if Dr. Mountin could suggest how we can replace those persons who are leaving our service and going to the Public Health Service because they get perhaps a little more money than we can afford to pay.

DR. MOUNTIN: There are a few instances in which, as I said, we are drawing on the local organizations. These instances are not many. We are guarding against it, but we are confronted with a legal situation in which we have to take a person who is certified and who wishes to come. I don't know how to answer your question regarding recruitment by State or local agencies or what to suggest except just to beat the bushes and look around locally, and also to keep your training program in operation.

I think we are all going to have to take folks of perhaps a little lesser grade of training and experience than we would like. We are prepared to dilute our organization with folks, I hope not wholly untrained, but perhaps only partially trained. That is the only suggestion I can make.

DR. MITCHELL: We are unable to take persons of less preparation without violating a State statute.

DR. MOUNTIN: Then I would say, have your State statute revised or get an exemption. That is all we can do, Doctor. We can't let qualifications, even though they are written into law, block us from

doing an essential job. I don't think we can go before the country evading our obvious duty because we have set up standards for personnel that can't be met. That is the only answer I have. I feel reasonably certain that if you go before the personnel body, whatever it is in your State, and explain the situation, you will get some sort of exemption whereby you can employ people temporarily, pending the time when ones who meet the standards become available.

CHAIRMAN PARRAN: The next discussion will be on Industrial Hygiene; Dr. J. G. Townsend.

DR. TOWNSEND: We know that the industrial expansion now in progress brings in its wake numerous health problems affecting the working population. Do these health problems have any significant effect on the rate and quality of our industrial production? If so, what provisions are being made today to solve these problems?

Although today we know how to control the majority of industrial health hazards, the application of that knowledge lags far behind, so that even in normal times a large proportion of our industrial workers are confronted with working conditions unfavorable to health and well-being. Even in normal periods the loss of time due to all types of disability in industry amounts to the staggering total of 350,000,000 days a year, or considerably more than 1,000,000 work years a year. This burden confronts the defense program and must be reckoned with in any production schedule.

There is still another factor which must be realized in any discussion of the relationship between industrial health and the national defense program. If we do not today take steps to create safe and healthful working conditions for the workers employed in our defense industries, then we may anticipate that after the emergency is over there will be thousands of men and women whose health will have been irreparably damaged

because of exposure to harmful conditions in those industries. The socio-economic implications of this fact also merit serious consideration.

What then are the specific industrial health problems which we must solve if we would avoid delay in the defense program and impaired national health after the emergency?

Needless to say, industrial mobilization in recent months has greatly augmented industrial health problems. Able-bodied men are being drawn into military service and are being replaced in industry by women, young adults, and older men. Many of these new workers are not as physically fit as the men they replace, and many of them, especially women, are unaccustomed to an industrial environment. Unless that environment is made safe for these new industrial recruits, and unless these workers are made health and safety conscious, we may expect a marked rise in accident and disease rates.

The problem of fatigue, so important in the first World War, will again appear as a result of the speed-up in industrial production. Hazardous chemicals will be used with little or no time to determine in advance their toxic nature. We may expect crowding in many factories, and under the pressure of the emergency we may expect a tendency to relax the eternal vigilance so necessary for the prevention of accidents and diseases among workers. Dr. Parran has stated that our industrial machines are rated as the most efficient in the world, and he rightfully insists that the men and women who operate these machines should be given the opportunity to do so with a comparable efficiency.

These, in brief, are some of the industrial health problems facing us today. Have we the organization and the program for solving these problems?

Fortunately, the groundwork laid by research during the past quarter century, and the organization developed during the past several years for the application of this research by industry and by the States, finds us better prepared to cope with industrial health problems than at any other time in our industrial history. It is universally conceded that the prevention of conditions inimical to health is always cheaper and more effective than attempts to correct them after they have gained headway. We know that every job can be done safely by applying our present knowledge of industrial hygiene.

Ordinarily, the legal responsibility for protecting the health of our workers is a function of official local public health agencies. In view of the fact, however, that industrial expansion for defense purposes has been instigated by the Federal Government, the communities where such expansion arises may reasonably expect the Federal Government to assist them in accomplishing the task of protecting and improving the health and efficiency of the workers in defense industries. Only by so doing may we assure ourselves of an uninterrupted flow of materials so vital for the defense program.

The organization which has been effected to achieve this objective may be described as follows. The Health and Medical Committee of the Federal Security Agency, a defense organization, has appointed a Subcommittee on Industrial Health and Medicine, the duties of which are to advise on the industrial health and medical aspects of national defense. This subcommittee also promulgates policies and suggests means of coordinating all industrial hygiene activities for the national defense.

The Subcommittee on Industrial Health and Medicine has recommended that the Division of Industrial Hygiene of the National Institute of Health assume leadership in achieving the objectives previously cited.

This designation is based on the fact that the Division of Industrial Hygiene has more than 26 years of experience in research and related problems, and at present has the personnel, facilities, and relationships with national, State, and voluntary agencies directly concerned with industrial hygiene problems.

Realizing that the responsibility for the protection of the health of our millions of workers lies finally with the States, the Division of Industrial Hygiene of the National Institute of Health was reorganized. The Division now consists of two sections, based on the major activities of the Division, and three units which function as a service supply to the two sections and which also have certain non-related functions. The two sections include one on States' Relations and the National Defense Program and another which embraces all the research work of the Division. The units are medical, engineering, and statistical.

On February 17 and 18 of this year, a conference was held for the purpose of developing a nation-wide program of industrial hygiene in defense industries. This conference, sponsored by the Division of Industrial Hygiene of the National Institute of Health, was attended by representatives from the various State industrial hygiene units, the Subcommittee on Industrial Health and Medicine of the Defense Council, and prominent leaders in the field of industrial hygiene.

At this conference, the following pressing problems in industrial hygiene were defined:

1. Further expansion in personnel, facilities, and funds of State industrial hygiene units and of the Division of Industrial Hygiene of the National Institute of Health.

2. Aid to military establishments, upon request of these establishments, in evaluating health hazards and in the training of personnel.

3. Surveys of commercial shipyards, airplane plants, and establishments producing military vehicles and munitions, and the training of industrial hygiene personnel in these industries as needed.

4. Promotion of first-aid in the construction of industrial plants, especially those in isolated areas.

5. Toxicological investigations of materials vital to national defense, notable among which are toluol, TNT, lead azide, and vinyl cyanide.

The conference recognized the importanc of environmental sanitation surrounding isolated industrial areas, but was informed that this problem is being handled by local health authorities with the aid of other divisions of the United States Public Health Service.

The program finally adopted by the conference, and now in effect, envisaged a close working relationship between the Division of Industrial Hygiene of the Institute, the various State industrial hygiene units, and other agencies, both governmental and non-governmental, such as the United States Department of Labor, the Council on Industrial Health of the American Medical Association, industry, and labor. The program being applied in each important industrial area has the following objectives:

1. The evaluation and control of the various health hazards resulting from exposure to dusts, fumes, gases, vapors, and other materials.

2. The provision of advisory services to industry in connection with the construction of new plants and the renovation of old plants, so that adequate facilities for health and safety may be included in the plans.

3. The promotion of physical examinations and medical services for the workers, in order that the benefits of preventive and curative medicine may be applied promptly to their individual health problems.

4. The control of communicable diseases among workers through a control program developed in connection with the general public health services of the community.

It is believed that the above program can best be fulfilled by supplementing the facilities of State and local units through the expansion of the services now provided by the Division of Industrial Hygiene of the National Institute of Health. Congress has recently made available additional funds for this work and today there are several mobile units, each consisting of a physician and an engineer, working in key defense industries, in cooperation with the State departments of health. By July of this year it is planned to have approximately 20 such units in the field.

In the work of these mobile units, the engineering personnel are concerned with evaluating the working environment and recommending ways and means for the control of any health hazards revealed by the investigation. The medical personnel, on the other hand, work very closely with local medical organizations, such as the State committees on industrial health of the American Medical Association. These medical officers appraise present medical control services in industry and recommend improvements in these services where indicated. The problem of personal relationships, or mental hygiene in industry, is emphasized. Plant management is informed, either directly or through the medical department, if one exists, of the importance of such provisions as periodic inspection and appraisal of plant sanitation and occupational exposures, followed by the adoption and maintenance of adequate control measures; the provision of first-aid and emergency services; and prompt and early treatment for all illnesses resulting from occupational exposure. Impartial health appraisals of all workers and the

provision of rehabilitation services for the correction of defects are additional functions of a medical department which are advocated.

The work of the Division of Industrial Hygiene has been aided in many of the defense industries by the splendid cooperation afforded it by the War Department. The Secretary of War, in a circular memorandum dated March 18, 1941, has informed all the branches of the War Department employing civilians for industrial work and those having direct jurisdiction over contract production that the Division of Industrial Hygiene of the National Institute of Health has the necessary facilities for effectively rendering services for the protection of workers in these industries. The Secretary of War recommended that full advantage be taken of the services available and has designated the Safety Officer, Office of the Chief of Engineers, to coordinate these activities. As a result of this cooperative program, the Division of Industrial Hygiene of the National Institute of Health has already developed for the Section on Construction, Division of the Quartermaster General, minimum requirements for first-aid rooms and infirmaries in new construction projects.

On April 4, 1941, the Chief of the Ordnance issued a memorandum designating the Chief of the Safety Division to act as the Ordnance Department representative for coordinating all industrial health and medical surveys which are to be conducted by the Division of Industrial Hygiene of the National Institute of Health at all Ordnance establishments and Government-owned, contractor-operated munitions plants. A systematic investigation of all ordnance establishments is being started on May 5.

Time does not permit discussing the many other activities of the Division of Industrial Hygiene in the defense program. Brief mention should be made of the Division's work in the training of personnel

recruited for the mobile units functioning in the various States, the preparation and dissemination of both technical and nontechnical information on the various phases of industrial hygiene, and the fundamental research work in progress at our laboratories on such substances as toluol, lead azide, solvents, metals used in airplane construction and munitions, and components of synthetic rubber and plastics. Standards for benzene, hydrogen sulfide, carbon disulfide, and carbon monoxide have been established. These standards define the amount of the toxic substances which may be permitted in the work places without harm to the workers.

There is now in progress a program of research on the problems of aviation medicine, including a study of the efficiency and safety of oxygen administration apparatus at high altitudes and low temperatures. These are only a few of the many activities with which our research section is concerned.

It is believed that all State health commissioners are well aware of their responsibility in giving all possible aid to industry, so that the health and efficiency of employees in defense industries will be maintained at a high level. It is realized that most State health departments have only organizational nuclei so far as industrial hygiene services go. The Division of Industrial Hygiene of the National Institute of Health stands ready to assist State health departments in bringing adequate health protection measures to industrial workers, and welcomes any suggestions which will further the program discussed herein.

It should be borne in mind, however, that the resources of the Division are limited and that each State, especially those with large industrial populations, should make every effort to utilize what funds it can spare for industrial hygiene purposes. It is our sincere belief that if surplus funds be available, a portion of such funds could very well be

diverted to strengthen industrial hygiene services. We do not know of any more serious bottleneck to the defense program than that occasioned by lost time among workers due to disability. Much of this lost time and its attendant delay in the production schedule may be prevented be well-established principles of industrial hygiene. Your attention is, therefore, directed to the grave responsibility which all of us must share in solving some of the problems of industrial hygiene previously discussed.

In closing, it is desired to emphasize that the industrial hygiene program which has been briefly sketched has been created, not as an emergency improvisation, but as an integral part of our national life in the future. We must not forfeit the gains we have made for the sake of expediency. All of us must assume our share of the responsibility and coordinate all of our efforts, so that the men and women in our industries will attain a high level of efficiency and health. (Applause)

CHAIRMAN PARRAN: Thank you, Dr. Townsend. Are there any questions? Is there any discussion?

If not, we shall pass on to the last paper on the afternoon program, Venereal Disease Control, by Dr. R. A. Vonderlehr.

DR. VONDERLEHR: Dr. Parran, Ladies and Gentlemen: As many of you know, the appropriation for venereal disease control in the fiscal year 1942 contained in the President's Budget Message was set at six and a quarter million dollars. That is $50,000 more than during the current fiscal year. Hearings were held last Friday and there is nothing which indicates that we will get any less or any more than that amount. Of course, the appropriation is dependent upon the action which the House Subcommittee takes, and subsequently upon the action taken by Congress.

Since the beginning of the national defense program, two important events have occurred which relate to the control of the venereal diseases. The first of these was the mobilization under the Selective Service System, which makes possible through the examination of a large representative portion of the manpower of the country a much more exact determination of the prevalence of syphilis and which also presents an opportunity to bring a larger number of men infected with syphilis and gonorrhea under treatment than ever before in the United States. The second relates to the instructions by the Congress that the facilities for the control of the venereal diseases, developed as a civilian health program in the preceding years, be intensified and adapted to the new requirements created by the present mass movement of large population groups.

On the basis of preliminary reports from 41 States and Territories, the program of serologic blood testing for syphilis in the examination of Selective Service candidates has shown that among the first 950,000 men examined approximately 50,000 had positive tests. In addition, the physical examinations of selectees before local Selective Service medical boards and Army induction boards have resulted in the rejection of substantial numbers of men with the lesions of early syphilis and with gonorrheal infections.

An attempt has been made to ascertain whether the selectees with positive serologic tests have been brought to physical examinations to clinch the diagnosis of syphilis, and, if so, whether they have been placed under treatment. This investigation shows that in most States existing epidemiologic and treatment facilities have been very inadequate. In the 20 States and Territories which have reported on the follow-up of selectees, only 43 per cent of the positive reactors have been brought in for physical examination and less than 31 per cent have been classified as being under

medical care for syphilis. No definite reports are as yet available on the follow-up of men rejected for gonorrheal infections, but there is every reason to believe that the follow-up and treatment services for these men are of a grade inferior to those rendered the men infected with syphilis.

These facts clearly indicate failure to develop an effective scheme for the follow-up and treatment of persons suspected of being infected with syphilis and gonorrhea. This situation is hardly surprising because reports from State departments of health at the beginning of the present fiscal year showed that only 65 per cent of the venereal disease clinics throughout the nation were provided with follow-up workers and that the remainder did not employ even a part-time follow-up investigator. Only 15 per cent of the venereal disease clinics in the United States employed full- or part-time workers with some degree of special training in the principles of venereal disease epidemiology. In other words, at least one-half of the venereal disease clinics in existence at the beginning of the present fiscal year depended for contact-tracing and case-finding on part-time and untrained investigators, and two-thirds of the remaining clinics had no follow-up personnel. The present inadequacy of follow-up work not only in the general venereal disease control program, but also in regard to the work connected with the Selective Service System, is chiefly due to failure properly to train personnel. It is also possible that the present system of generalized public health nursing is not effective because of an inadequate number of nurses employed and their limited experience in venereal disease control work.

The reports submitted by State health officers also show that in most instances there has been no clear-cut organizational procedure for

reference back to Selective Service Boards of men originally rejected for the venereal diseases and subsequently rendered noninfectious by adequate therapy. This problem is especially acute as it relates to the deferment of selectees with gonorrhea, in whom, through the use of modern chemotherapeutic treatment, postponement of military service for a period of more than one month is extremely illogical. Routine procedures should be developed for the immediate return to the Selective Service Boards upon the completion of treatment of all selectees deferred solely for venereal disease infections.

To provide effective facilities for all men found to be infected with the venereal diseases under the Selective Service System, the following plan is recommended:

1. The establishment of procedures for the follow-up of all selectees rejected for syphilis and gonorrhea, including the provision of treatment, the tracing and examination of their contacts, and the treatment of such of these contacts as are found to be infected.

2. The establishment of special investigators who will study the results of all examinations and laboratory tests performed on selectees to appraise the efficiency of follow-up service both for the selectee and for his contacts and to hold such infected persons under treatment until rendered noninfectious.

3. The organization of a procedure for reference back to Selective Service Boards of men originally deferred for syphilis and gonorrhea and subsequently rendered noninfectious by adequate treatment.

4. The provision of sufficient trained personnel to insure effective contact-tracing of alleged civilian contacts with gonorrhea and syphilis patients in the military personnel through a cooperative arrangement between all military medical and civilian health authorities.

5. The establishment of a program applying the above methods and technics to the specific problems of the control of syphilis and gonorrhea in industry and especially in the national defense industries.

6. The development of an effective educational program to inform the public and the armed forces of the need for adequate follow-up and treatment services and to discourage those who are infected from seeking treatment from quacks or other unlicensed treatment sources.

The progress reports submitted by State and Territorial health departments, as of the first half of the present fiscal year, showed that more than 50 per cent of patients with syphilis who sought licensed medical care were in either the late or the late latent stages of this disease. In public clinics, less than 12 per cent of the total syphilis case load was composed of previously untreated patients who were admitted with primary or secondary syphilis. Since the major concern of the health department in the attack upon syphillis is the early, infectious patient, it is essential that everything possible be done to provide adequate treatment for such early patients and to discourage the attendance of patients with late and late latent syphilis beyond the time when adequate treatment has been given.

There is additional evidence from other sources to show that late and late latent syphilis now receive major attention in public clinics. Approximately 60 per cent of the antisyphilitic treatments given in such clinics were to patients with syphilis in these late stages.

In most clinics there is a tendency to devote far too much time to case-holding of patients with late and late latent syphilis. So long as epidemiologic and treatment facilities are not utilized for the purpose of controlling early and infectious syphilis and gonorrhea, but to insure

continuous care for patients with late syphilis, there will be insufficient follow-up and therapeutic services available to cope with the essential and fundamental public health problem. If a successful war is to be waged against the venereal diseases, every effort must be made to provide adequate treatment for all early infectious patients and to find and treat, if necessary, all persons who have had contact with patients in this category.

Experience in defense areas shows that gonorrhea is the venereal infection which occurs with much the greater frequency. One gains the impression that this situation is due to neglect of this disease, because knowledge is available which would eliminate it as a public health problem within several years if a reasonably adequate program were developed. The Congress has also expressed a deep interest in the gonorrhea problem and has placed upon the Public Health Service the responsibility of developing a concerted national attack.

A marked rise in the number of laboratory tests performed to aid in the detection of gonorrhea and some increase in the number of persons under treatment by private physicians and public clinics offer a degree of encouragement for the future of the gonorrhea control program. The following measures should be intensified, however, to insure the greatest progress:

1. Provision of facilities for the clinical management of gonorrhea in all venereal disease clinics throughout the United States. It is still true that almost 30 per cent of the nation's venereal disease clinics do not admit patients with gonorrhea. This situation exists in spite of the fact that Section XV, paragraph 3, of the Regulations Governing Allotment of Venereal Disease Control Act funds stipulates that "free diagnostic and treatment facilities for both syphilis and gonorrhea shall be provided by all health departments or clinics receiving funds under this Act." If a larger percentage

of the venereal disease clinics in the country do not change their policy materially with reference to gonorrhea, it may be necessary to prohibit the reallotment of Federal funds to clinics which refuse to admit such patients.

2. There is considerable evidence to show that State and local health departments are distributing sulfonamide compounds which are already archaic. Sulfanilamide especially should be replaced by newer sulfonamide compounds of much greater therapeutic efficacy. In the last two Conferences of State and Territorial Health Officers, you were informed that sulfathiazole was much more effective than any other sulfonamide compound which had been studied carefully up to that time. This situation still exists; yet, in spite of the proven efficacy of sulfathiazole for gonorrhea, only 200,000 tablets of this compound were reported as having been purchased and distributed by State health departments during the first half of the present fiscal year, as compared with three and one-quarter million sulfanilamide tablets. The Public Health Service has developed a system for rapid clinical appraisal of the efficacy of the new sulfonamide compounds and these findings will be made available upon request to your State venereal disease control officer. Until the exact efficacy of the numerous sulfonamide compounds available for the treatment of gonorrhea has been established, health departments should purchase these compounds in quantities sufficient to last for only a period of from two to three months.

3. The need continues for the development of facilities for the culture of the gonococcus in public laboratories. The culture remains the most efficient method for determination of cure in this disease.

4. Many States regard the gonorrhea problem as so unimportant that no progress records are available from them indicating the control measures against gonorrhea. In many other States the progress reports are meager and only incompletely made. Consequently, it has been very difficult for the

Public Health Service to obtain reasonably exact information as to the extent of the facilities and services available in the United States for the control of gonorrhea. Such progress records are important not only to determine the progress which has been made from year to year, but also to ascertain the needs which now exist or which may arise in the future.

Immediate attention should be given to the utilization of educational and public relations technics and materials as a practical arm of venereal disease control, not only in areas of armed and industrial defense concentrations, but also with a view to laying a groundwork for the future program. The implications of this statement should be clearly perceived, for the future course of venereal disease control work may depend on the degree to which a sound educational and public relations program is carried on during these crucial days.

As an immediate step, the Public Health Service is substantially increasing its venereal disease educational services to the States. A consultation and advisory plan makes available trained workers who will collaborate, upon request, in the development of State and local activities. The production service makes available professionally written and designed publications, posters, exhibits, radio and motion picture materials at costs considerably below what individual States would have to expend for similar material.

The Public Health Service is becoming increasingly concerned both with the quality of educational materials being produced by the several States, and with the organization of the educational programs. Studies recently made indicate a failure to appreciate many fundamental and practical pedagogical, public-relations, and graphics factors in the preparation of publications, and a failure to adjust programs to changing conditions. To say this is to assess no blame. Perhaps not even in the more fortunately situated States and municipalities is it feasible to employ the necessary staff of trained and experienced persons to carry out a program of both production and use.

At this point I would like to comment on some of the attempts, which in my opinion are rather atrocious, to reproduce the publications of the Public Health Service. If any of you are particularly interested in this aspect of educational work, I would like to invite you up to my office to show you some horrible examples of such reproductions. It is reproductions of that type that we are trying to discourage. I think the reproductions are made primarily in order that the State health departments may be able to utilize the penalty mailing privilege in distributing this educational material, but when the attempt has been made one hardly recognizes the pamphlet as having any relationship whatever to the original educational pamphlet or material which it was intended to reproduce.

The practical solution for production of effective materials would be to establish a cooperative relationship between the States and the Public Health Service whereby the facilities of all agencies could be utilized to the fullest extent.

The Public Health Service is in a position to make use of the finest talent available in the educational fields, and, as in the other fields, will not hesitate to do so to aid the States better to do their tasks. It is prepared also to give full credit in the materials themselves to the various State departments of health. As you know, Federal funds available under the Venereal Disease Control Act may be utilized for the purchase of educational materials produced by the Public Health Service, as well as to finance the production of educational materials in the State or local health department.

Some of our own materials are on exhibit in the outside hall at the present time. (Applause)

Faced with the problem of acute shortages of trained personnel, it is imperative that every effort be made to conserve our resources by assignment of tasks to those best qualified to handle them most economically and efficiently.

It is recommended, therefore, that State health officers seriously consider the advisability of utilizing more directly and actively the venereal disease education consultative and production services of the Public Health Service.

Consideration should also be given to the more rapid development of broad programs of public health education, utilizing materials produced jointly. Such activities would be of mutual benefit to venereal disease control and general public health, since the practical potentialities of health education in any specific field can be realized only through a comprehensive and integrated program.

In the interest of economy and greater efficiency, the Public Health Service, therefore, urges the development and adoption of a cooperative plan of genereal health education, which would be coordinated on Federal, State, and local levels.

And, finally, two more recommendations are made for improvement of the entire venereal disease control program as it relates not only to invulnerable national defense, but also to its final successful prosecution throughout the United States.

1. Intensive training in the epidemiology of the venereal diseases of otherwise qualified new and old personnel, especially in contact-tracing and case-holding of patients with infectious or potentially infectious syphilis and gonorrhea.

2. The development of measures to discourage the present tendency of treatment sources to over-treat patients with late and late latent syphillis, especially when such treatment sources fail to provide adequate therapy and follow-up for patients with early infectious venereal diseases.

CHAIRMAN PARRAN: Thank you, Dr. Vonderlehr. Are there any questions on Dr. Vonderlehr's presentation, or any discussion? Dr. Riley, as Chairman of the Committee on Venereal Disease Control, do you have any questions to ask?

DR. ROBERT H. RILEY (Maryland): Dr. Parran, I will ask them when I make my report Saturday.

CHAIRMAN PARRAN: Are there any reports which any of the State health officers would like to make concerning situations in their States?

DR. C. F. McCLINTIC (West Virginia): Mr. Chairman, in working with the county health units, I would like to ask if we would be justified in refusing to O.K. purchases of anything but sulfathiazole.

DR. VONDERLEHR: At the present time I think one would be justifed in refusing to purchase any of the sulfonamide compounds other than sulfathiazole for the treatment of gonorrhea. How long that condition will be true, we cannot say. It is barely possible that we may be able to find a drug which is more effective than sulfathiazole. Sulfathiazole, however, at the present time, when properly employed, will cure 95 per cent of the people with gonorrhea, and we can't do much better than 95 per cent.

CHAIRMAN PARRAN: Dr. Vonderlehr, in further response to Dr. McClintic's question, would you be prepared to give him the factual data based upon authoritative study which would support his position in dealing with his clinics?

DR. VONDERLEHR: I mentioned in my report, Dr. Parran, that we do have analyses of clinical studies being conducted on a cooperative basis all over the country, utilizing the sulfonamide compounds. I would be glad to go over these with you, Dr. McClintic, while you are here, and send copies to your staff in West Virginia.

DR. MARION F. HARALSON (Hawaii): Mr. Chairman, simply as a matter of interest, out in Hawaii we examined 3,700 selectees. Our serological positive rate ran, as might be expected, about 2.3 per cent. Out of the 3,700, however, we found only four positive G.C.s.

CHAIRMAN PARRAN: I wonder if any of our Canadian friends have anything to say concerning their experiences with venereal diseases incident to mobilization or the war industries. Dr. Phair, have you anything of interest to suggest or to tell us about that?

DR. J. T. PHAIR: Nothing, Dr. Parran. Fortunately, when war was declared, the mobilization for active service implemented the question of serological examination. The situation was carefully canvassed and such examination was recommended by the officers of the Dominion Council of Health to the three units, the Army, the Navy, and the Air Force. For a time the Air Force carried out that recommendation, but neither the Army nor the Navy did anything more than accept it in the spirit in which it was proffered.

We have little data of a reliable character as to the incidence of venereal diseases among the armed forces, except the continued assurance from the medical officers of the Army and Air Force of the effectiveness of the control measures. This assurance is supplemented by the fact that the Army and other military units do report to the Provincial health officer cases of venereal disease occurring among the troops. While we have little accurate data of a national character, our information in Ontario would lead us to beleive that the observations of the medical staff are correct. There is very little primary syphilis or gonorrhea among the troops, in contrast with the situation that existed some twenty-five years ago.

We have, I think, in almost all of the provinces, now strengthened our Provincial venereal disease control measures, having in mind that the Provincial authorities assume the responsibility for protecting the members of the Army,

Navy, and Air Force from civilian exposure. I believe that with the legislation which was recently passed under Dr. Gregoire's aegis in Quebec, every Province now has an adequate control program, designed specifically, with amendments added to the measures which were in effect prior to the war, to give the maximum in the way of protective service to both civilian and military forces.

DR. DONALD G. EVANS (Washington): Do the Army and Navy induct men with positive serology?

DR. VONDERLEHR: I think that in the case of men with positive serology an attempt is made to ascertain whether or not the man is infected with syphilis. If he has syphilis he is not inducted into the Army or Navy.

CHAIRMAN PARRAN: By that, you mean a second examination is made, plus a clinical examination?

DR. VONDERLEHR: In the case of men with positive serology, after the second examination is made and it is positive, it is automatically assumed the man has syphilis and he is not inducted. Or, if clinical evidence of syphilis is found during the first examination he is rejected.

DR. PAUL J. JAKMAUH (Massachusetts): I would like to ask through the Chairman if any provision is being made to notify the States into which troops are coming, or in which an interchange of troops will take place very soon. For instance, our National Guard troops who are in other cantonments and who will return to us--will they be reported to the State authority?

CHAIRMAN PARRAN: Is there a representative from the Army here who can answer that question? Can you answer it, Dr. Vonderlehr?

DR. VONDERLEHR: I am sorry I cannot be very helpful. My impression is that changes are taking place so rapidly in the Army that we are far behind. We do not know how many troops are moved from place to place. We would know of any large-scale maneuvers that are going to be held, but, except for maneuvers, we would know nothing whatever of transfers from one post to another within the Army.

DR. McCORMACK: I think Dr. Jakmauh is referring to men in the National Guard who have completed their year of service and then come back. He would like to know whether the authorities would be notified of that.

DR. VONDERLEHR: We have a statement which Dr. Riley and his committee approved yesterday. This statement will be presented on Friday and will answer that question.

CHAIRMAN PARRAN: It occurs to the Chairman that our liaison officers could very properly see to it that State health officers are notified of any anticipated movement of considerable bodies of troops into any State. If that point is not covered by the report, we can take it up with the liaison officers.

DR. A. L. MILLER (Nebraska): I wish to ask Dr. Vonderlehr about the errors in serological examinations. Have you any information on that, as to how frequently they occur, showing positive when they should be negative, and vice versa?

DR. VONDERLEHR: The reliability of performance of serological tests for syphilis is rapidly increasing in the United States. During the past five years, since annual studies of the efficiency of performance of these tests were begun, we have noted an improvement of several hundred per cent, and since most of the serological testing for the Selective Service System has been done in State laboratories there would be a very small error either in terms of false positives or false negatives. We do not have as good information with reference to municipal and private laboratories within the State, but certainly as far as the State laboratories themselves are concerned the work is now on a very firm basis.

CHAIRMAN PARRAN: Do you have any information from your own State on that score?

DR. MILLER: The tests in Nebraska, in the congested areas, run about 3 per cent positive for syphilis, and in our rural areas it is less than 1 per cent. Up to last month there were 70 counties which showed no positives among their selectees. It is my understanding, however, that the laboratory at Hot Springs sends out some of these blood tests to various laboratories for the purpose of subjecting them to examination. Is that under your direction? We recently went through one of those, and I am just wondering.

DR. VONDERLEHR: If you accept our invitation, you go through one of those every year, Dr. Miller. We plan them every winter, and the specimens come for examination not only from Hot Springs but from several other points throughout the country. That is the annual study of efficiency of performance of serologic tests.

CHAIRMAN PARRAN: Are there any other questions?

DR. ARTHUR McMCORMACK (Kentucky): Dr. Parran, I would like to express my gratitude to the Service, and to Dr. Vonderlehr especially, for the improvement in the quality of the serological test as a result of these annual examinations. They have not only kept us on our toes, but they have made us realize the necessity of checking on our laboratories. It really caught me entirely unaware; and, if any of you haven't a premarital law yet, when you get it there is one thing that is rather going to astound you. The State health commissioner is required to approve all laboratories that make premarital examinations. Of course, I thought that would be purely perfunctory. I thought all that would be necessary was for them to write in and say they had a laboratory, and I would say that it was approved. When we began to make the serological tests on the basis that Dr. Vonderlehr had established for our own laboratory, we found only about a third of the private laboratories in the State could come anywhere in the neighborhood of being approved; and

in three or four of the most popular ones, it would have been quite as easy to have determined the presence of syphilis by pitching up a dime as by having a serological test. The only difference was that pitching up a dime wouldn't have cost anything.

That condition has been corrected and in our fifty-three private laboratories which are now approved we are having absolutely no difficulty, but we examine them every three months. We send ten specimens to them every three months. They are also examined by Dr. Kahn's laboratory, and frequently by Dr. Maloney's. Whenever we are in doubt we send our own specimens to the laboratory for testing. We find it is very important to keep yourself on your toes because you can slip very easily if you are negligent.

DR. MILLER: What is the passing grade?

DR. VONDERLEHR: It was determined in this way: Two years ago last October there was an assembly of laboratory directors and serologists at Hot Springs, Arkansas, and one of the committees during this assembly arbitrarily set as an acceptable standard any serologic test which had a specificity rating of 99 per cent, that is, any test which did not have more than 1 per cent false positives on specimens known to come from people who do not have syphilis.

In order to be regarded as satisfactory, the percentage of sensitivity, or the ability of the test to detect syphilis in the case of syphilitic patients, should not be more than 10 per cent below the rating of the control serologist. We have literature on that subject which I will be glad to send you.

DR. CORNELIUS A. HARPER (Wisconsin): Dr. Vonderlehr, have you any knowledge of the number of so-called Wassermann-fast cases, cases which after a long series of treatments still remain positive? Have you any

FRIDAY MORNING SESSION

May 2, 1941

The session of the Conference held on Friday morning, May 2, was devoted to the reading and consideration of the reports of committees. The Surgeon General presided.

REPORT OF THE COMMITTEE ON PROFESSIONAL EDUCATION AND QUALIFICATIONS OF PUBLIC HEALTH PERSONNEL.* Presented by Dr. W. L. Bierring, Chairman

The Joint Committee on Professional Education and Qualifications of Public Health Personnel desires to record its recognition of the contribution of previous committees under the efficient chairmanship of Doctor J. N. Baker. During the past five years these committees have set the standards for a basic and accepted pattern of training for the major classifications of public health personnel.

During this period a nucleus of well-trained public health personnel has become available, a development which has distinctly influenced the better organization of State, Provincial, and local health departments and greatly extended modern public health service into many new areas.

It is also fitting to express the highest appreciation for the fine cooperative spirit on the part of university schools of public health in establishing courses of training in accord with the needs and activities of State, Provincial, and local health departments, as well as in faithfully maintaining the standards of training and qualifications approved at previous sessions of these annual conferences.

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*Members of this committee are also members of the Joint Committee on Professional Education and Qualifications of Public Health Personnel of the Conference of State and Provincial Public Health Authorities of North America and the Conference of State and Territorial Health Officers.

knowledge of the ratio between those, so-called, and those which can be changed by treatment?

Dr. VONDERLEHR: We have no idea of how many of those there are in the United States. We do know that serologically-fast cases are produced primarily by irregular treatment, treatment given irregularly and in an insufficient quantity. For that reason it is highly important that the patient, at least during the first several months of therapy, get the treatment at regular intervals. Failure to give regular treatment is the great cause of serologic fastness.

CHAIRMAN PARRAN: Are there any further questions? Are there any announcements?

DR. ARTHUR McCORMACK: I would like to announce that the Committee on the Social Security Program will meet for about fifteen minutes for organization purposes in the Surgeon General's office upon adjournment, and then will meet at nine-thirty on Thursday morning to take up seriously the matters which will be suggested to you this afternoon. We would be pleased to have suggestions as to anything else you have in mind with regard to the social security program, or we would be glad to have you come before the committee with any suggestions you have to make.

CHAIRMAN PARRAN: Is Dr. Eliot here, or has she gone? You are meeting with her at the Children's Bureau tomorrow.

DR. EDWARD S. GODFREY: Mr. Chairman, I would like to announce that the Committee on Hospital and Medical Care will meet in Dr. Mountin's office, room 325, Thursday morning at ten-thirty.

CHAIRMAN PARRAN: Is there anything further to come before the session this afternoon? If not, we stand adjourned until Thursday afternoon.

...The meeting adjourned at three forty-five o'clock p. m. ...

FRIDAY MORNING SESSION

May 2, 1941

The session of the Conference held on Friday morning, May 2, was devoted to the reading and consideration of the reports of committees. The Surgeon General presided.

REPORT OF THE COMMITTEE ON PROFESSIONAL EDUCATION AND QUALIFICATIONS OF PUBLIC HEALTH PERSONNEL.* Presented by Dr. W. L. Bierring, Chairman

The Joint Committee on Professional Education and Qualifications of Public Health Personnel desires to record its recognition of the contribution of previous committees under the efficient chairmanship of Doctor J. N. Baker. During the past five years these committees have set the standards for a basic and accepted pattern of training for the major classifications of public health personnel.

During this period a nucleus of well-trained public health personnel has become available, a development which has distinctly influenced the better organization of State, Provincial, and local health departments and greatly extended modern public health service into many new areas.

It is also fitting to express the highest appreciation for the fine cooperative spirit on the part of university schools of public health in establishing courses of training in accord with the needs and activities of State, Provincial, and local health departments, as well as in faithfully maintaining the standards of training and qualifications approved at previous sessions of these annual conferences.

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In formulating this report, special acknowledgment is accorded to the eminent consultants attending this Conference for valuable counsel in determining the educational aspects of qualifying public health personnel.

The committee recognizes that it is confronted at this time by two major problems concerned with the training of public health personnel, viz.

1. The recruiting of personnel for the present national emergency.
2. The safeguarding of nationally accepted standards of personnel qualifications.

As a stimulus to recruiting additional personnel, the committee recognizes the value of the orientation or introductory program for public health personnel as it is now being carried out by the United States Public Health Service. This program will promote a familiarity with the Federal, Provincial, and State public health policies and will further act as a means of appraising, testing of aptitude, and acquainting the new personnel with the emergency public health problems now confronting these agencies.

The committee highly endorses the action on the part of university schools of public health in establishing special courses of training in industrial hygiene, venereal disease control, public health administration, and other specialized fields of public health practice.

In regard to the second major problem, it is the opinion of the committee that the established standards of training in the nine recognized schools of publ health in the United States and Canada be maintained so as to insure competent and trained personnel to help meet the present and future needs of public health work.

At previous conferences the qualifications of the following classificatio of public health personnel were accepted:

1.	Health officers.	(1935 and 1938)
2.	Public health nurses.	(1939)
3.	Sanitation personnel.	(1935 and 1938)
4.	Public health dentists.	(1935 and 1938)
5.	Venereal disease officers.	(1939)

Before recommending definite standards of training and qualifications of the additional classifications of vital statisticians, public health educators, and public health laboratory personnel, the committee requests further opportunity for study and counsel with the national associations concerned with such public health specialties.

For each of these classifications a subcommittee with consultants has been selected for conference with the following organizations:

1. Vital statisticians.

   The American Statistical Association and the Subcommittee on the Educational Qualifications of Public Health Statisticians, American Public Health Association.

2. Public health educators.

   The Subcommittee of the Committee on Educational Qualifications, American Public Health Association.

3. Public health laboratory personnel.

   Conference of Directors of State and Provincial Public Health Laboratories and the Subcommittee on Education and Qualifications of Public Health Laboratories, American Public Health Association.

After these conferences have been satisfactorily completed an interim report will be submitted regarding acceptable standards of education and qualifications of each classification.

After all of these standards and qualifications have been established, it is recommended that the United States Public Health Service edit and publis a special bulletin which will contain the following:

1. Regulations relative to the training of personnel under Title VI, Social Security Act, and the Federal Venereal Disease Control Act.

2. Educational requirements and qualifications of public health personnel included under the established classifications.

3. Text of Title VI of the Social Security Act.

4. Text of the Federal Venereal Disease Control Act.

5. Official Trainee Application Form.

Such a bulletin will be valuable for reference and will serve as a guide for university schools of public health and all public health agencies interested in the qualifications and recruitment of adequately trained public health personnel.

In order to promote unity in thought and action in the training of public health personnel, the committee has appointed a subcommittee to confer with a similar committee representing the Association of University Schools of Public Health.

The committee endorses the principle of personnel administration on a merit basis and recommends that the recruiting of new personnel be in conformity with such principles. In order to safeguard merit system standards during the present emergency, the Committee suggests the desirability of establishing appropriate interim classifications containing qualifications reasonably attainable under existing circumstances.

The committee has given careful thought to the actions and recommendations contained in this report and submits the same for approval by this Conference.

The motion to adopt the report was seconded by Dr. H. Allen Moyer (Michigan).

Dr. J. W. Mountin brought to the attention of the Conference a letter from Dr. C. D. Swope of the American Osteopathic Association requesting that the Committee on Professional Education and Qualifications reconsider the matter of granting to the degree, "Doctor of Osteopathy," status similar to the degree, "Doctor of Medicine," for purposes of basic qualification of health officers, and further requesting that funds be allocated to the College of Osteopathic Physicians and Surgeons for the training of osteopaths in

public health work. Dr. W. L. Bierring moved that the letter be referred to the Association of Public Health Schools, since this Association has been organized to evolve greater uniformity among the various schools with regard to training and the content of courses of instruction. The motion was seconded and carried.

It was proposed that the report be amended to provide that Dr. A. T. McCormack (Kentucky) act as consultant to the committee on the professional education and qualifications of clinical pathologists, and that Dr. R. A. Vonderlehr serve in a similar capacity with regard to the education and qualifications of social workers. The amendment was seconded and carried.

An amendment was offered to provide that the Public Health Service should endeavor to secure an appropriation of funds which would permit direct allotments to schools of public health for the training of public health personnel, since the amounts received by the schools from tuition under the present training program are not sufficient to enable the schools to meet their obligations. The amendment further proposed that aid to students in the form of stipends should be provided as at present, by grants-in-aid to the States. The amendment further proposed that, because of the varied demands growing out of the current national emergency, the Conference recommend that schools of public health continue their short courses for health officers and develop other courses in related skills. The amendment was seconded and carried.

With the inclusion of these amendments the report of the Committee on Professional Education and Qualifications of Public Health Personnel was unanimously adopted.

REPORT OF THE COMMITTEE ON THE SOCIAL SECURITY PROGRAM --- Presented by Dr. A. T. McCormack, Chairman

Title VI of the Social Security Act provides that regulations shall be made by the Surgeon General of the United States Public Health Service governing payments to States from funds appropriated under the provisions of the Act. From time to time since the passage of the Social Security Act in 1935 it has been the privilege of this committee to consider the development of public health in the United States under the Act and to recommend modifications and additions for simplifying the procedure and making the benefits of this Act available to the people of the several States.

The Federal-States relationship under Title VI has been generally recognized as the ideal relationship between the States and the Federal Government. Those of us who are connected with the Public Health Service and those of us who represent the States as executive health officers have recognized that we have a common responsibility and that we are in a partnership that has been recognized by law for the high purpose of improving the health of the people of our country. At the beginning it was recognized that the first five years would be a trial period. It was realized that there had been uneven development of administrative public health procedures in the several States, and during these years every effort has been made to improve the central organization in each State and at the same time to develop local health services which would be available to the smaller governmental units in the State.

During this period certain practices have been permitted which we would now like to see modified or stopped; others, we believe, should be specifically included in the regulations.

Your committee recommends the inclusion of items in budgets to pay expenses of individuals selected by the State health officer to attend such specified regional and national meetings as are approved by the Surgeon General.

It is recommended that the State health authorities in each State consider the establishment as soon as practicable of an adequate formula for the allotment of funds within each State.

It is recommended that no Social Security Act funds be used for the payment of salaries for State health officers after July 1, 1941.

It is recommended that the percentage of available appropriations allotted to each State be charged so that the allotment for "Population" will be 27.5 per cent, for "Special Health Problems" 45 per cent, and for "Financial Needs" 27.5 per cent.

It is recommended that there shall be included under "Special Health Problems" a new sub-section "(e)":

(e) National defense needs, including the environments of army posts, cantonments and maneuver areas, and defense industrial areas.

It is recommended that any unexpended balances from allotments to States under the present regulations for the current or subsequent fiscal year be reallocated under the new subsection (e) of Section (2) for defense health needs.

Your committee has considered the several addresses that have been mad in regard to emergency health and sanitary problems arising from national defense needs and it urges consideration by each State health authority of the adjustment of resources and program to defense needs, which are paramount.

The committee recommends that the State health authorities confer with their respective Governors in regard to the problems of law enforcement, the

passage of county and rural zoning laws, and the passage of legislation providing sanitary control through permit or license by State or local health departments.

It is further recommended that each State health department arrange for a conference with other interested agencies to consider a planned development for a civil defense program, and that adjacent States prepare to pool their resources in the development of such a program.

The detailed plans and procedures under Title VI of the Social Security Act have been so simplified that each of us now knows exactly what reports and what requests for allotments and payments should be made. It is urged that budgets be prepared and submitted at the times required by the regulations so as to avoid delay in approval and congestion in the administrative office. The attention of State health officers is called to the necessity of routing all correspondence in regard to budgets and reports through the regional representative's office so that decisions may be expedited.

After reading the report Dr. McCormack moved that it be adopted by the Conference. The motion was seconded by Dr. W. H. Pickett (Florida).

Dr. Walter L. Bierring (Iowa) raised an objection to the section of the report prohibiting the supplementing of salaries of State health officers with funds made available under Title VI of the Social Security Act. This objection was seconded by Dr. F. P. Helm (Kansas), and supported by Drs. Donald G. Evans (Washington), Edward E. Hamer (Nevada), and Clifton F. McClintic (West Virginia).

Dr. J. N. Baker (Alabama) moved that the section to which objection was made be amended to read: "It is recommended that no Social Security Act funds by used for the payment of salaries of State health officers after the adjournment of the next regular session of the legislatures in the respective States."

Whereupon Dr. Bierring withdrew his objection and seconded Dr. Baker's motion for amendment.

With the inclusion of this amendment the report of the Committee on the Social Security Program was unanimously adopted by the Conference.

REPORT OF THE COMMITTEE ON HOSPITAL AND MEDICAL CARE --- Presented by Dr. Edward S. Godfrey, Chairman

A number of suggestions were placed before the committee, all of which can be summarized in one question: What is to be the role of public health agencies in the broadening field of governmental participation in hospital and medical care?

A number of programs are already operating on a national scale, such as those of the Farm Security Administration and the National Youth Administration Others are in the process of formation. For example, the so-called Community Facilities Bill, now before Congress, provides for Federal funds to be expended in defense areas for building and operating not only water supply and sewarage systems, but also hospitals and health centers. A number of proposals are also being made to provide Federal aid for medical care to special groups such as transients, workers in defense industries, the indigent and the medically needy, and men rejected by the draft because of physical defects.

Some of these proposals are certain to go into effect in the near future and all of them should be of vital concern to Federal and State health agencies. The United States Public Health Service or other Federal agencies charged with the administration of funds for such purposes can deal, in the States and localities, only with such agencies as have the necessary authority to receive Federal funds and to expend them for the construction and operation of facilities, or for any other purposes specified in the Federal act, which may include the provision of general medical care. It is believed that most

State health departments do not at present have adequate authority to permit receipt of Federal funds for such purposes, and therefore the Federal agencies will be obliged to deal with other State agencies or directly with the localities concerned.

The report received by the Conference last year from this committee drew attention to the need in both Federal and State governments for "a single health agency charged with all governmental functions that are predominantly medical." In line with this statement and in recognition of its special importance in the present rapid expansion of governmental health and medical services, the committee offers the following resolutions:

RESOLVED, that this Conference strongly recommends that the expenditure of Federal funds for health facilities and medical care be administered by the Federal Security Agency.

RESOLVED, that the provision of health facilities and medical care is an important interest of State health departments, and that the Conference urges its members to secure for their departments the necessary authority: first, to construct and operate health facilities such as general hospitals, health centers, water supply and sewerage systems, or to supervise their construction and operation by other State and local agencies; and, second, to participate in programs of general medical care.

The committee is deeply concerned with the results of the examinations made under the Selective Service Act. The fact that 43 per cent of men examined have been found physically unfit for full military service has serious implications for the health of the nation. Therefore, the committee wishes to reiterate the resolution submitted by it and adopted by this Conference on September 17, 1940, to the effect that persons rejected because of physical defects amenable to treatment within a reasonable period of time might be

considered for acceptance as beneficiaries of the Public Health Service for the correction of their defects.

Nothing has been done on a national scale towards rehabilitating these persons since this resolution was adopted. The Committee therefore offers the following resolutions designed to implement its previous recommendations:

RESOLVED, that this Conference recommend to Congress that legislation be enacted which will permit the acceptance as beneficiaries by the United States Public Health Service of men who have been examined under the Selective Service Act of 1940 and placed in deferred status because of correctable physical defects or ailments, and who make application to the Surgeon General of that Service, and that a suitable appropriation be provided for this purpose.

RESOLVED, that the Conference of State and Territorial Health Officers is much concerned by the health conditions revealed by the physical examinations made under the Selective Service Act and urges Federal and State health agencies to institute a program designed to prevent or discover and treat defects and ailments among persons of both sexes now below draft or working age so that in the future persons reaching military or working age will be better equipped physically and psychologically to take their parts in civilian or military life.

After reading the report Dr. Godfrey moved that it be adopted by the Conference. The motion was seconded by Dr. A. T. McCormack (Kentucky) and was carried unanimously.

REPORT OF THE COMMITTEE ON VENEREAL DISEASE CONTROL --- Presented by Dr. R. H. Riley, Chairman

The report of the Committee on Venereal Disease Control was presented in five sections, as indicated below:

Section I: Administrative Costs of the Venereal Disease Control Program

In considering appropriations for the control of the venereal diseases, the United States Congress has requested that the Public Health Service make a careful study of the administrative costs of the venereal disease control program in the States and work out an acceptable plan of venereal disease control administrative practice with the health officers of the respective States. The Congress has further expressed the desire that these administrative costs, including both State and Federal funds, be limited as far as is consistent with the prosecution of an effective venereal disease control program.

A careful study of administrative costs for venereal disease control work has been completed by the Public Health Service and a uniform plan is described. This plan includes provision of the following personnel and services:

1. The State venereal disease control officer. The travel allowance of such officer should not be included as an administrative item because, in most States, this officer performs some duties connected with field work.

2. The clerical assistant to the venereal disease control officer. The clerical assistant should perform those duties pertaining to the venereal disease control officer's correspondence, filing, or other general office work in this section of the health department.

3. Any other clerical or stenographic personnel at the State level, provided the major portion of their activities is concerned with general office work under the immediate supervision of the State Venereal Disease Control Officer. This item

includes personnel concerned with the accounting of funds, but excludes personnel concerned with statistical activities since the latter are included in the category of personnel performing duties connected with consultation and dissemination of technical information.

4. All activities concerned with the administration of the merit system on the State level.

5. A proportion of the items budgeted for office supplies and office equipment used primarily by personnel classified as administrative. These costs should be indicated in terms of the percentage of the total central office costs as well as in terms of an actual monetary figure.

The total administrative costs of a State program for the control of the venereal diseases vary according to the population, the size of the State, and the cost of government in States with a large area and relatively sparse population. In general, however, it is recommended that the total cost of administration of the venereal disease control program shall not exceed five per cent of all funds expended for this phase of public health work in States with a population greater than one million, and ten per cent in States with a population of one million or less.

After reading this section of the report Dr. Riley moved that it be adopted by the Conference. The motion was seconded by Dr. W. H. Pickett (Florida) and was carried unanimously.

Section II: A Plan to Insure Adequate Venereal Disease Control Measures for Personnel Discharged from the the United States Army, Navy and Coast Guard.

The rigid physical requirements of the Medical Corps of the United States Army, the Bureau of Medicine and Surgery of the United States Navy,

and the United States Public Health Service make it possible for the Army, the Navy, and the Coast Guard to select from the civilian population men for service who are not infected with the venereal diseases. State and local departments of health have been cooperating with these Federal agencies to aid in this selection of a healthy armed force and to insure the organization of an effective venereal disease control program in all areas where such personnel are concentrated.

Under the Selective Service System more than a million men will be inducted into the Army each year for the next five years. After the end of the first year of service approximately 1,000,000 men will be separated from the Army each year. These large numbers do not include the enlisted personnel which serve in the Army, the Navy, and the Coast Guard. In spite of the most effective venereal disease control program which can be developed under existing conditions, it is certain that a considerable number of these men will be infected with the venereal diseases during their service period. The members of the Conference of State and Territorial Health Officers therefore recommend to the Secretary of War, the Secretary of the Navy, and the Federal Security Administrator the following plan to insure the adequate treatment of men infected with the venereal diseases in the military services and to prevent the transmission of such diseases by these men upon their return to civilian life:

1. A thorough physical examination to detect the venereal diseases, including a serologic blood test for syphilis and including also, if clinically indicated, necessary microscopic smears and culture examinations for the detection of the gonococcus, for each man before his discharge from the military services.
2. The administration before discharge of a minimum of 20 doses of one of the trivalent antisyphilitic arsenical drugs and 20 doses of one of the heavy metals by the medical corps of the

responsible branch of military service to each man found to be infected with syphilis.

3. The administration before discharge from the military service of two grams of sulfathiazole per day for ten successive days to each man found to be infected with gonorrhea.

4. The adequate treatment before discharge of all men found to be infected with chancroid, granuloma inguinale, and lymphogranuloma inguinale to insure that such infected men are rendered incapable of transmitting their infections to others.

5. Before discharge from the military service of any man infected with the venereal diseases, the responsible medical corps should communicate with the health department of the State to which the infected man expects to proceed, in order to obtain from the State health officer assurance that free treatment facilities will be available at the discharged man's new place of residence.

6. If no health department facilities for the free treatment of such infected men are available, the man should be retained by the responsible medical corps until there is reasonable assurance that he has recovered from his infection.

After reading this section of the report Dr. Riley move that it be adopted by the Conference. The motion was seconded by Dr. C. A. Harper (Wisconsin) and carried unanimously after some discussion of the fifth recommendation.

Section III: Induction and Treatment of Selectees Infected with Gonorrhea

Whereas selectees called under the Selective Service Act and found to have uncomplicated gonorrheal urethritis are not accepted for induction into the Army; and

Whereas this policy results in turning back into the civilian population infected persons by whom the infection may be spread; and

Whereas modern methods of treating this disease result in prompt cures in a high proportion of cases: Therefore be it

Resolved, That it be the opinion of the members of this Conference that the objectives of the Selective Service Act and the health and welfare, both of persons called for service thereunder who are found infected with uncomplicated gonorrheal urethritis and of the civilian public, could best be served if such selectees were promptly inducted into service and treated; and be it further

Resolved, That the members of this Conference recommend such action and that copies of this resolution be sent to the proper officials of the War Department and the Selective Service System.

After reading this section of the report Dr. Riley moved that it be adopted by the Conference. The motion was seconded by Dr. Walter L. Bierring (Iowa) and was carried unanimously.

Section IV: Proposed Revision of the Regulations Requiring Cooperation of Local Law Enforcement Authorities in the Repression of Prostitution before Federal Funds are Reallotted to Local Health Departments for the Control of the Venereal Diseases.

The members of the Thirty-Eighth Annual Conference of State and Territorial Health Officers approved, on May 9, 1940, recommendations for the repression of prostitution. These recommendations described the important relationship borne by tolerated and segregated prostitution to the spread of the venereal diseases and defined the responsibility for the application of repressive measures.

Since this formal action by the members of the Conference, the prostitution problem in the United States has become even more grave. This is particularly true in those areas where armed forces or national defense workers are concentrated. In some such areas recent studies have indicated the presence of prostitutes equivalent in number to one per cent of the population. Under such conditions, so great is the number of exposures of men and boys to infected or potentially infected prostitutes that there is grave danger that venereal disease rates will increase greatly.

In those areas where prostitution is tolerated and segregated, the people assume, since a venereal disease control program utilizing State and Federal aid has been organized, that toleration of prostitution and an effective venereal disease control program are compatible. All health authorities know, on the contrary, that the greater the number of sexual contacts of healthy people with infected persons or those harboring the spirochete or gonococcus, the higher will be the incidence rates for syphilis and gonorrhea. Certain members of the local police and local health authorities may distort the facts either through ignorance or political considerations or because of a desire to participate in the financial benefits derived from this vice. To encourage the repression of prostitution because of its public health importance and to inform public-spirited citizens of the incompatibility of tolerated prostitution and effective venereal disease control measures, the following revision of Section XV, paragraph 7, of the Regulations Governing the Allotment and Payment of Venereal Disease Control Funds is approved by this committee and submitted with a recommendation that it be adopted by the members of the Conference:

7. In reallotting funds under this act for local venereal disease control services, the State health officer shall give due consideration to the relatively higher prevalence of syphilis and gonorrhea in urban areas, provided that after conference with the local health officer, the State health officer shall require from the agency of local government responsible for law enforcement against prostitution within the area a written statement that during the period when Federal funds are made available a program of repression of prostitution will be enforced. This statement from the director of the agency of the local government responsible for law enforcement against prostitution shall certify that during the life of a local venereal disease control budget, which includes Federal funds, such law enforcement authority will vigorously enforce all local and State laws prohibiting prostitution, procurement, solicitation, and assignation. Failure of the responsible authority to enforce such laws during the life of the venereal disease control budget will disqualify the local health department for further reallotments of Federal funds for venereal disease control work until satisfactory proof is produced by such local authority that said laws are actually being enforced.

After having read this section of the report Dr. Riley moved that it be adopted by the Conference. The motion was seconded by Dr. W. H. Pickett (Florida).

Upon the vote being taken, the motion to adopt the section of the report as read was carried, Dr. M. F. Haralson (Hawaii) voting "No."

Section V: Reciprocity Between States in Premarital Examinations to Detect Syphilis

There are, at present, a total of 24 States in which statutory provisions have been enacted requiring premarital blood tests for syphilis. In 8 additional States similar provisions are pending before the respective legislative bodies. It is therefore expedient to render compliance with the provisions of these statutes as free from inconvenience to the general public as is consistent with the duty which is imposed.

A very distinct inconvenience is frequently caused to prospective marital partners who reside in widely separated jurisdictions. In such instances it is necessary for each party to proceed to the place at which the necessary legal formalities are to be complied with at a date sufficiently antedating the actual ceremony to permit a report of test findings to be secured. This time interval may be a week or longer. Much of this unjustifiable inconvenience could be obviated through the institution of free and full reciprocity between the various States or in such States as the wording of the enactment does not specifically provide that the test be performed in the laboratory of the State in which the legal ceremony is to take place.

In support of a plea for free reciprocity in premarital blood testing it is the expressed opinion of the Committee on Evaluation of Serodiagnostic Tests for Syphilis that an entirely satisfactory level of efficiency in the conduct of serologic tests has been attained by practically all State laboratories and that such laboratories may be depended upon to supply a finding which is considered accurate within the limitations of the methods which are at present in general use. On this basis the acceptance of serologic reports from the various States would not in any way detract from the social value

of the enactments and would result in a marked reduction in the inconvenience at present imposed upon applicants for marriage licenses in jurisdictions other than that of their residence.

It is realized that reciprocity in premarital serologic examinations is definitely interdicted by the wording of the statutes in certain States. In others, especially in those in which the actual operation of the provisions of the law is placed under the guidance and supervision of the health departments, a program of full and free reciprocity would seem to be entirely feasible. A liberalization of this degree would serve to prevent unjustifiable antagonism toward the measures, a circumstance which is always detrimental to the advance of social progress.

Itis therefore recommended that full reciprocity be extended by the States in the matter of acceptance of premarital serologic reports in all instances in which the procedure is not specifically interdicted by the wording of the various statutes.

Reciprocity should also be furthered by the delegation of broad powers to State health departments in matters pertaining to the practical administration of the enactments of premarital legislation under advisement at this time.

After reading this section of the report Dr. Riley moved that it be adopted by the Conference. The motion was seconded by Dr. Edward A. McLaughlin (Rhode Island).

Dr. Edward S. Godfrey (New York) moved that the section of the report be amended to provide that the Public Health Service release a list of approved laboratories, and further to provide that reciprocity be limited to State and (or) local laboratories certified by the United States Public Health Service. The motion was seconded by Dr. A. T. McCormack (Kentucky) and carried.

Thus amended, the section of the report was unanimously adopted.

REPORT OF THE COMMITTEE ON INTERSTATE AND FOREIGN QUARANTINE
Presented by Dr. A. J. Chesley, Chairman

The report of the Committee on Interstate and Foreign Quarantine was presented in seven sections, as indicated below.

I. Ratproofing of Ships Used in Foreign Trade

Ratproofing of all ships in foreign trade is recommended. Owing to war conditions, many old merchant vessels are being used. Ship inspection is very difficult, since reports of departure are not made by radio, new routes are followed, and emergencies may necessitate calls at ports where plague infection is present but not recognized. Therefore it is imperative that quarantine procedures be maintained at fullest capacity at all United States ports and that ratproofing be done wherever needed.

Experience under similar conditions during wars in different parts of the world indicate that all measures for defense against plague and yellow fever[1] should be rigidly enforced. If necessary, increased funds should be provided.

This recommendation was seconded by Dr. Stanley H. Osborn (Connecticut) and unanimously adopted.

II. Plague

Today it may be considered that plague infection exists in wild rodents in eastern Oregon, eastern Washington, the major portion of California,

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[1]U. S. Public Health Service, Public Health Reports, March 1, 1940, Yellow Fever: Its History, Occurrence, and Control.

several counties in Idaho, Nevada, Arizona, New Mexico, Utah, Wyoming, and Montana[2], and also in Western Canada[3]. Infected rodents have been found within 150 miles of the western boundary of Nebraska. Infection has been demonstrated in the various species of ground squirrels, chipmunks, rabbits, marmots, prairie dogs, wood rats, and several other species of wild rodents. There is no reason to believe that the infection will not extend into the Mississippi valley and throughout the eastern United States unless a well financed, well organized force be constituted to eradicate the infection from the present area in which it exists.

The results of the campaign in the original plague region in California, covering some 15,000 square miles, are believed to be ample demonstration that, if properly financed and actively prosecuted, the eradication of infection in rural areas is entirely practicable. There is no good reason to assume that this is an insuperable problem. It is recommended that a campaign be inaugurated to extend for at least a period of five years at an estimated cost of $500,000 a year, this campaign to be financed jointly by the United States Public Health Service and the various States concerned.

The measures employed would include survey and eradication procedures, carried out jointly by shooting, by fumigation of burrows, and by distribution of poison. The examination of rodents obtained would be performed either at a central laboratory, as at present, or at several branch

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[2]U. S. Public Health Service, Bulletin 254, Plague in Western Part of the United States.

[3]Canadian Journal of Public Health, Jan. 1941, Plague Surveys in Western Canada.

laboratories. Preferably there should be some central supervising head to coordinate the work carried on in the various States.

Aside from the probability of the extension of the infection eastward, there is a serious danger of the introduction of infection into the cities in the infected areas. Plague in wild animals has been demonstrated in proximity to several of these communities, and it requires only the intermingling of the infected wild rodents with the domestic city rats to start an epidemic within the community. This has occurred in the past, notably in Oakland and Los Angeles, California.

The recommendation concerning plague was seconded by Dr. A. T. McCormack (Kentucky) and was unanimously adopted by the Conference.

III. Typhus Fever

Typhus fever is spreading. Its control depends upon reduction of the rat population, since it is transferred to man by rat fleas. Trapping, poisoning, ratproofing, garbage control, and the use of vaccine have been found effective and practicable. These measures are recommended for adoption by State and local health departments.

This recommendation was seconded by Dr. J. N. Baker (Alabama) and was unanimously adopted by the Conference.

IV. Psittacosis

Psittacosis infection in parrakeets from Florida has been demonstrated. California lacks funds to carry on expensive laboratory tests required to certify the freedom of parrakeets from psittacosis. There is reason to

suspect that certain virus pneumonias may be due to psittacosis infection. It follows that health authorities should warn people to keep away from birds of the psittacine family, especially parrakeets, and that sanitary regulations should be adopted and enforced similar to the Connecticut State Health Department, Regulation #48, Sanitary Code, June 30, 1939, which provides: "The importation, purchase, breeding, sale, or giving away of birds of the psittacine family is hereby prohibited, provided that the importation or breeding of such birds for scientific research or exhibitions in public zoological gardens may be permitted subject to the approval of the State Department of Health."

United States Public Health Service regulations provide for six months' quarantine before parrots can be admitted into the United States. In view of the fact that States are not in a position to assume responsibility for the interstate shipment and inspection of birds, the committee urges every State to cooperate with the Public Health Service by promptly reporting violations of regulations concerning the interstate shipment of psittacine birds.

Having read this section of the report, Dr. Chesley moved that it be adopted by the Conference. The motion was seconded by Dr. A. T. McCormack (Kentucky) and unanimously carried.

V. Tularemia

Tularemia has recently become prevalent in the New England States, and the health authorities there recommend laws or regulations which will prevent interstate shipment of live wild rabbits, since they are commonly the source of infection for human cases. Such statutes or regulations are usually part of the laws relating to game and fish rather than the codes of the health departments.

The committee recommends for consideration of States the following (Sec. 3102, General Statutes of Connecticut, 1930; Fish and Game, Tularemia Rabbits, Hares): "No person shall transport into this State any wild hare or rabbit or liberate in this State any such animal which has been so transported without a permit from the Board. The Board may quarantine any such animal imported into this State and may make rules and regulations as to the importation and liberation of any such animal. Any person who shall violate any provision of this Section or any rule or regulation made under any such provision shall be fined not more than $100.00 or imprisoned not more than 30 days or both."

Dr. S. H. Osborn (Connecticut) seconded the recommendation which was adopted by unanimous vote of the Conference.

VI. Common Carrier Sanitation

The Committee recommends that the Public Health Service develop comprehensive codes covering all phases of sanitation relating to common carriers, including water supply, sewerage disposal, food handling, ventilation, etc.

The recommendation was seconded by Dr. Stanley H. Osborn (Connecticut) and unanimously adopted by the Conference.

VII. Sanitation Codes

The Public Health Service has prepared definite codes relating to milk, restaurant sanitation, and frozen foods. It is recommended that additional codes be prepared covering general sanitation in defense areas, housing sanitation, water supply, sewage disposal, and other phases of sanitation.

The recommendation was seconded by Dr. A. T. McCormack (Kentucky) and unanimously adopted by the Conference.

Doctor McCormack called attention to the variety of plumbing installations in Federal housing projects, some of which do not conform to State and local regulations. The Surgeon General called upon Mr. Hoskins to explain the variance of the Federal plumbing code with those of the various States. Mr. Hoskins explained that the Federal code had been adopted by a committee of Federal representatives from the several agencies concerned, in cooperation with the Bureau of Standards. These specifications have, in many respects, simplified some of the complicated and excessive requirements of the older State and local ordinances.

REPORT OF COMMITTEE ON RECORDS AND REPORTS*
Dr. W. C. Williams, Chairman

Doctor W. C. Williams, Chairman of the Committee on Records and Reports was not present. On his behalf, Dr. J. N. Baker (Alabama) moved that the Conference adopt the report of the Committee on Records and Reports as presented to the Conference of State and Provincial Health Officers on April 28, and insert it in the transactions of the Conference with two additional recommendations which were read. The motion was seconded and unanimously carried.

Accordingly, the report as presented to the Conference of State and Provincial Health Officers and the additional recommendations (numbers 9 and 10 under the heading "Recommendations") are given below:

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*Members of this committee are also members of the Joint Committee on Records and Reports of the Conference of State and Provincial Health Authorities of North America and the Conference of State and Territorial Health Officers.

I. General Considerations

The personnel of the field consultant staff has remained unchanged since the 1940 meeting, with the exception that in January 1941 Dr. C. Mayhew Derryberry succeeded Dr. J. O. Dean as the United States Public Health Service representative--the change being due to Dr. Dean's assignment by the Public Health Service for special work in Puerto Rico. The committee wishes to renew at this time its previous expression of appreciation to the United States Children's Bureau and the Public Health Service for the most timely assistance rendered by members of their respective organizations assigned to work with the field staff.

The field staff, upon invitation of the State health officers concerned, has made studies of records, reports, and administrative practices during the year in the following States and localities: Idaho, Utah, Colorado, Connecticut, Indiana, Missouri, and the city of St. Louis. The staff assisted the State health departments of Oregon and Washington in the setting up of certain specific recommendations affecting a limited number of local health departments. Return visits were made to the States of Oregon, Washington, and Connecticut for the purpose of rendering assistance in connection with the procedures previously undertaken as a result of field staff recommendations. Staff members presented formal papers or participated in meetings of the American Public Health Association, Western Branch of the American Public Health Association, and conferences of the Washington and Oregon Health Officers Associations.

Since early in March 1941 the field staff has had its headquarters in Washington and has engaged in a cooperative study of records and reports needs and uses by the Federal agencies concerned.

II. Specific Committee Activities

The committee and consultant staff met with representatives of the United States Children's Bureau and the United States Public Health Service in Washington on October 21, 22, and 23, 1940, for the purpose of studying (a) the various report forms (74 in all) required by the different Federal agencies, (b) the uses to which data thus collected were put, and (c) the minimum needs of each particular agency concerned. The conference brought out three significant facts:

1. There is much duplication of reporting at the present time.
2. Considerable simplification and consolidation of existing reports would be possible at Federal and State levels.
3. Additional knowledge of Federal needs is required before any definite plan for revision of forms can be begun. Moreover, certain tentative conclusions regarding State and local problems should be rechecked.

The committee and consultant staff met again on March 21, 1941, to consider further the findings and procedures proposed in connection with the October 1940 meeting. Conferences were held with Surgeon General Parran of the Public Health Service and Drs. Daily and Yerushalmy of the Children's Bureau for the purpose of determining the time and conditions under which assistance of the field staff could be most effectively used in a study of the reporting needs and uses of activities reports by their respective staffs. Since that date the field staff has been devoting full time to the work with the Public Health Service and the Children's Bureau in accordance with the plan of procedure outlined. At the March 21 conference, certain details incidental to the clearance of survey reports with the regional and Washington offices of the Federal agencies were also discussed and procedures were agreed upon.

An audit of receipts and expenditures, other than the routine audit by the auditing division of the Treasurer's Office of the State of Tennessee, has not been made since the above method of disbursing funds has been acceptable to the Commonwealth Fund. Although the original Commonwealth Fund grant for this project expires on June 30, 1941, sufficient funds are available to continue salaries, travel, and contingent expenses of the full-time staff members, perhaps through the present calendar year. The Commonwealth Fund has agreed to the use of these funds for such purposes as long as they are available.

III. Recommendations

It is recommended that:

1. The Public Health Service and the Children's Bureau be urged to make every reasonable effort to provide consultant service on records, reports, and correlated administrative practice to State health departments through their respective regional areas and to assume some financial responsibility for the regional service. The two present full-time staff members of the committee could be utilized to good advantage in the training of such personnel through actual field practice.
2. The Commonwealth Fund should be petitioned to extend its grant, perhaps on a reduced basis, for continuation of the field staff beyond December 31, 1941.
3. The present plan of assistance to Federal agencies in determining minimum reporting needs of these agencies should be continued.
4. The details incidental to the assignment of field staff members to a particular State should be cleared with the proper regional office of the Children's Bureau and the Public Health Service prior

to the time the visit is made, and the visit should be made at a time when a representative or representatives of these agencies can be present in the State, at least for the latter part of the visit.

5. In planning future visits to the States primary consideration should be given to finishing the job already begun in a number of States, giving due consideration to urgent problems in States not previously visited.

6. The revised activities report should be available for use in a limited number of States (proving grounds) beginning January 1, 1942, and for general use by January 1, 1943, unforeseen and unpredictable contingencies not interfering.

7. The committee should give special consideration to combining the statistical activities report with the annual plan required for budget justifications.

8. The States in each region should give consideration to a plan by means of which a limited amount of Social Security funds might be made available for consultant service in their respective areas, in the event Federal funds per se are not available.

9. The previous recommendations regarding the elimination, simplification, and consolidation of activities, budgets, and financial report forms should be reaffirmed and the objectives outlined therein should be pursued with increasing vigor. All State health officers are urged to cooperate to the fullest extent in connection with requests by Federal agencies for accounting assistance and consultation.

10. A small subcommittee of not less than three nor more than five members of the present Records and Reports Committees of the

Conference of State and Provincial Health Authorities and the Conference of State and Territorial Health Officers should be created by joint action of the President of the State and Provincial Health Authorities, the Surgeon General of the United States Public Health Service, and the Director of the United States Children's Bureau, this committee to have the authority to act in an executive capacity for the State and Provincial and State and Territorial Committees on Records and Reports.

After adoption of the report of the Committee on Records and Reports the chairman asked if there was any further business. Dr. A. T. McCormack (Kentucky) rose to state that on behalf of the State and Territorial health officers and others present he wished to express appreciation to the Surgeon General and the Public Health Service for both the content of the Conference and the manner in which the proceedings had been conducted. General applause indicated the agreement of the Conference with Dr. McCormack's remarks.

There being no further business, the Conference adjourned.

APPENDIX

REGISTRATION LIST OF THE CONFERENCE

ALABAMA	Dr. J. N. Baker, State Health Officer, Montgomery.
ALASKA	Dr. W. W. Council, Commissioner of Health, Juneau.
ARIZONA	Dr. J. B. Eason, State Superintendent of Public Health, Phoenix.
ARKANSAS	Dr. W. B. Grayson, State Health Officer, Little Rock.
CALIFORNIA	Dr. Bertram P. Brown, State Director of Public Health, Sacramento.
COLORADO	Dr. R. L. Cleere, Secretary and Executive Officer, State Division of Public Health, Denver.
CONNECTICUT	Dr. Stanley H. Osborn, State Commissioner of Health, Hartford.
DELAWARE	Dr. Edwin Cameron, Executive Officer, State Board of Health, Dover.
DISTRICT OF COLUMBIA	Dr. James G. Cumming, Director, Bureau of Preventable Diseases, District Health Department, Washington, D. C. Dr. C. C. Dover, Epidemiologist, District Health Department, Washington, D. C. Dr. D. L. Seckinger, Assistant Health Officer, Washington, D. C. Dr. George M. Leiby, Director, Bureau of Social Hygiene, Washington, D. C.
FLORIDA	Dr. W. H. Pickett, Executive Secretary and State Health Officer, State Board of Health, Jacksonville.
GEORGIA	Dr. T. F. Abercrombie, State Director of Public Health, Atlanta. Dr. G. G. Lunsford, Director, Division of Local Health Organization, Atlanta.
HAWAII	Dr. M. F. Haralson, Territorial Commissioner of Public Health, Honolulu.
IDAHO	Dr. E. L. Berry, State Director of Public Health, Boise.
ILLINOIS	Dr. R. R. Cross, State Director of Public Health, Springfield.
INDIANA	Dr. J. W. Ferree, State Director of Health, Indianapolis.

IOWA	Dr. Walter L. Bierring, State Commissioner of Health, Des Moines. Dr. M. E. Barnes, Director, State Hygienic Laboratories, Des Moines.
KANSAS	Dr. F. P. Helm, Secretary and Executive Officer, State Board of Health, Topeka
KENTUCKY	Dr. A. T. McCormack, State Health Commissioner, Louisville. Dr. P. E. Blackerby, Assistant State Health Commissioner, Louisville.
LOUISIANA	Dr. Ford Williams, Assistant Director of Health, New Orleans.
MAINE	Dr. Roscoe L. Mitchell, State Director of Health, Augusta.
MARYLAND	Dr. Robert H. Riley, State Director of Health, Baltimore. Dr. Charles H. Halliday, Assistant State Director of Health, Baltimore. Dr. A. W. Hedrich, Chief, Bureau of Vital Statistics, Baltimore.
MASSACHUSETTS	Dr. Paul J. Jakmauh, State Commissioner of Public Health, Boston. Mr. Arthur D. Weston, Chief Engineer, State Health Department, Boston.
MICHIGAN	Dr. H. Allen Moyer, State Commissioner of Health, Lansing.
MINNESOTA	Dr. A. J. Chesley, Secretary and Executive Officer, State Department of Health, St. Paul.
MISSISSIPPI	Dr. Felix J. Underwood, Secretary and Executive Officer, State Board of Health, Jackson. Dr. J. A. Milne, Director, County Health Work, Jackson.
MISSOURI	Dr. Harry F. Parker, State Health Commissioner, Jefferson City. Dr. John W. Williams, Assistant Health Commissioner, Jefferson City.
MONTANA	Dr. W. F. Cogswell, Secretary and Executive Officer, State Board of Health, Helena. Mrs. B. M. Phillips, Child Health Council, Helena.
NEBRASKA	Dr. A. L. Miller, State Director of Health, Lincoln.
NEVADA	Dr. Edward E. Hamer, State Health Officer, Carson City.
NEW HAMPSHIRE	Dr. Alfred L. Frechette, Director, Division of Venereal Disease Control, Concord.